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EVALUATION OF CHANGE

RALPH SLATER

Compiled and edited from lectures on psychoanalytic technique given by the late Karen Horney at the American Institute for Psychoanalysis during the years 1946, 1950, 1951, and 1952. Further lectures in this series will appear in subsequent issues of the Journal.

OUR TASK, as psychoanalysts, is to help our patients change. We conceive of neurosis as a character disorder, a way of life in which a person is compulsively driven in an unhealthy direction by a variety of rigid and conflicting needs. This precarious way of life begins in childhood with basic anxiety[1] and basic conflict,[2] and continues with the person's desperate and contradictory unconscious attempts to solve his inner conflict. Of these neurotic attempts at conflict solution, perhaps the most significant is the creation, in imagination, of an idealized self.[3] The idealized image becomes more real to the person than his real self, and his life becomes devoted to the attempt to actualize it. Our therapeutic aim is to help our patients change from striving mainly for self-idealizing to striving mainly for self-fulfillment.[4] Unless there is change in this direction, we cannot say that our therapeutic endeavors have been successful. It is not enough that a patient acquires insight, that he becomes aware of something he didn't know previously—knowledge without inner change is sterile.

It is therefore essential that we evaluate the degree and nature of change in our patients if we are to assess accurately the effectiveness of our work. This is easier said than done. Many factors make it difficult to evaluate change. Among these are the following:

1. We are dependent, to a degree, on what the patient communicates to us during the analytic hours. We do not have the opportunity to observe him at home and at work, among relatives, friends, and strangers. Also, we do not interview his wife, children, teachers, employers, employees, and peers. In short, we do not have the benefit of the observations of others, including people who see a good deal of him and who may have known him for a long period of time. It should be added, however, that the fact that the analyst does not see the patient as often as a spouse, for example, also has its advantages. A certain distance and objectivity may make it possible for the analyst to recognize and evaluate changes which are not recognized by those who live with the patient and see him daily.

The patient's own statements con-

Ralph Slater, M.D., New York University, 1938; diplomate, American Board of Neurology and Psychiatry; fellow, The Academy of Psychoanalysis; lecturer, American Institute for Psychoanalysis; practicing psychoanalyst.

cerning the ways in which he has or has not changed are often unreliable. For one thing, some patients are unconsciously compelled to exaggerate the degree of their improvement; they bring in reports of how much they have progressed in much the same spirit as the pupil who presents his teacher with a shiny red apple. Irrationally overoptimistic patients similarly exaggerate their progress. On the other hand, there are patients with equally powerful unconscious motives who are compelled to minimize or deny any change or improvement. Included in this group are patients who have to belittle the analyst and analysis, and those who have an intense aversion to change. In neither case can the analyst take at face value his patient's statements about progress and change. A second consideration is that the patient's and the analyst's concepts of progress often do not coincide. Thus, a patient will feel gratified because he has become increasingly successful in taking revenge upon his detractors, that is, on those who hurt his pride or frustrate his claims. In such a case, the analyst will recognize that his patient has changed, but not in the direction of self-fulfillment. This will also apply in those situations where the patient's change is on the basis of compulsive compliance, and where the change is a behavioral but not an inner one.

2. The analyst's neurotic tendencies, to the degree that they persist, will warp his judgment and make it difficult or even impossible for him to estimate the extent and nature of the patient's change. Thus, the analyst with some persistence of resignation as a way of life, which includes an aversion to and a disbelief in change, may be blind to evidences of it in the patient. On the other hand, a therapist's need to cure all his patients, and to do so as rapidly as possible, may make him see more change than has in fact occurred. In these instances, I am referring to neurotic residuals in the doctor. In addition to these, it is inherently difficult to recognize changes in the patient, since they are often subtle and slow to develop.

3. External changes may affect the patient, making it difficult for the analyst to determine whether the person's improvement (or, for that matter, his worsening) is due to them, or to the analytic process, or to both in varying degrees. Such factors as marriage, divorce, the death of a relative or friend, and economic and occupational success or failure may bring about changes in a patient. There are certain patients who are more likely than is warranted to attribute change in themselves to external factors. Analysts are less likely to do so, since they are not compelled to externalize to the same degree.

We may attempt to determine change in the patient by considering evidence from two points of view. The first of these is, is there less of the neurotic in the patient? We would raise and attempt to answer questions such as these. In general, is the person less driven by compulsions? Is he, for example, less pushed around by needs indiscriminately to please and placate others, to subordinate himself to others, to provoke abuse? Is he less compelled to belittle and disparage people, to prove himself superior to and triumph vindictively over them? Is he less coerced into attaining perfect freedom and self-sufficiency? Is he less anxious and less driven by an insatiable ambition? Does he make fewer irrational claims on people and on life? Is there a diminution in the rigidity and extent of his perfectionistic standards, and the severity of his self-contempt and self-accusation? Does he externalize less—

that is, is there a lessening of the need to attribute his inner feelings and thoughts to people and institutions other than himself? Is there less need to pretend to virtues that he really does not possess? To the degree that the answer to these and similar questions is "yes," to that extent the analyst can feel that the patient has changed, and in the direction of increasing psychic health.

As examples of this "less of the neurotic," I will mention two patients. The first of these had experienced giving Christmas presents to her fellow employees as a torture, because her presents had to be "absolutely the best. I couldn't even consider the possibility of mine being other than the best." Some years later she was able to give a Christmas gift which was nice, although not the absolute best, and "it didn't kill me. Quite a relief." At the same time this patient noted a decrease in her sensitivity to criticism. "Things don't bother me so much anymore—I'm less sensitive—I'm not hurt so deeply and so long by remarks." The other patient illustrates a decrease in unconscious pretending and self-deceiving. She said, "I'm not so sweet and self-sacrificing as I appear; underneath, I want quite a lot, but I want only expensive things, though I pretend otherwise."

The other point of view is a positive one, namely, is there more evidence of healthy thinking, feeling, and acting in the patient? In order to arrive at an answer, we would again raise and attempt to answer questions such as these: Does the patient sleep better, eat better, feel happier? Does he have more satisfying and enjoyable relationships with his fellows? Is he more spontaneous, more alive? Does he feel more deeply, and are his feelings appropriate and sustained? Is he able to express tender as well as angry feelings? Is he more honest with himself and others, more dependable, more courageous? Does he recognize and accept assets and limitations in himself and others? Is he able to work more creatively, in a more sustained and satisfying manner, and on his own initiative? Can he constructively criticize himself and others, and is he able to take criticism of himself and his work without undue upset? Can he enjoy both work and leisure? Can he take a stand, or yield, in accordance with his own inclinations and the requirements of his situation? Does he begin to question his standards, to ask himself, for example, is it really valuable, always, to be hard and tough and ready to do battle? To the degree that the answers to such questions are affirmative, to that degree we can feel convinced that the patient has changed in the direction of healthier living.

Evidence of increasing health may be found in the patient's dreaming. There may be a change in the pattern—thus, a person who rarely if ever dreams may begin to dream more, or rather, to remember more dreams, bring them in, and work on them. Conversely, a patient who has flooded the analyst with a super-abundance of material may begin to bring in fewer dreams. (Exactly the same can be said about memories of childhood experiences.) There may be a change in the attitude toward dreams, in the direction of increasing interest in and more productive associations to them. Also, change in the dream content may indicate change in the direction of increasing health. For example, dreams in which the person is a spectator of conflict may be replaced by dreams in which he is an active participant. Or, something new, or growing and developing, may appear for the first time. Something living may appear where before there was deadness. Con-

sider the dream of a woman who for a long time had complied with all demands, including unfair ones, while inwardly resenting the people whom she obeyed. She finally became able to say no to claims made on her, with a resultant decrease in resentment. In a dream she saw herself in a coffin. Suddenly her dead self in the coffin came to life and sat up, to everyone's surprise.

In the evolving doctor-patient relationship, the doctor will find evidence of change in the patient. Here the analyst's conclusions will be based on his own observations, feelings, and thoughts, as well as the patient's actions and words, and therefore will be more valid than if they were based solely on the latter. In the beginning, the patient experiences the analyst as magic helper, adversary, and intruder. He may be unduly conciliatory, hostile, defensive, and secretive. If the analysis proceeds successfully, the patient's attitudes change and this change is one that the analyst can see, hear, and sense. An over-effusive gratitude may gradually be replaced by an appropriate appreciation for help given. Defensiveness diminishes and the person becomes more honest and open. Fears of ridicule and contempt decrease, and the patient becomes more willing and able to expose what he has had to cover up to the analyst and to himself. Hostile tendencies to disparage and frustrate the analyst-adversary are gradually replaced by a sense of cooperation with another, helping human being in the effort of self-discovery. A hitherto frightened and timid person may become able to disagree with and even to criticize the therapist. Or, a cold and withdrawn person may become able to feel and express positive feelings toward the analyst. As the patient's need for rigid self-control diminishes, his previously not-so-free associations become freer, and there is less compulsive intellectualizing and more letting go during the analytic hours.

I could go on listing many changes in a patient's words about and attitudes toward the analyst, which the latter can observe and feel. From what has already been mentioned, however, it should be obvious that the analytic relationship offers the analyst an excellent opportunity to observe and evaluate change in his patient. I would add to this that visible changes in the patient's appearance are also available to the analyst. I recall a patient, a young woman who always struck me as being poorly dressed; her clothes never seemed to hang right. During the analytic work she came to realize that she thought of herself as closely resembling a certain movie actress in appearance and physique. Actually, the actress was three or four inches taller than my patient. After the patient accepted the fact that she was really 5′2″ tall, not 5′6″, she bought clothes which fit properly, and there was a distinct change in her appearance, which became aesthetically more pleasing. Similarly, there may be a change in a person's posture—for example, from bent-over and cringing to erect and confident. A person's eyes may change from dead and fishy to alive and warm. A voice may gain in assurance, while at the same time, there may be a noticeable decrease in restlessness and fidgeting. Here again, I could go on listing such changes, but it is already clear that the analyst can be guided in his task of evaluating change by observation of his patient's appearance and behavior.

To summarize and conclude, the analyst who wants to assess the effectiveness of his therapy must attempt to evaluate change in his patient. He must do this with some regularity—for example, every three or every six months—otherwise, he may not do it at all. He

will look for evidence that his patient is more spontaneous and less compulsive in his acting, feeling, and thinking. In doing this, he will pay attention not only to what the patient does and doesn't say, but to the totality of the patient's response—to what the person says and how he says it, what he does in work, how he gets along with people, what he dreams, how he dresses, and so on. And, of course, the analyst will also pay attention to his own feelings. An attempt must be made to determine whether or not a patient's progress is proportionate to the time and effort invested. In making this determination, the individual analyst's experience is invaluable. If there has been no progress, or less than might reasonably have been expected, the analyst must ask himself such questions as, what in the patient stands in the way of more growing, and what other ways and means can I use in tackling the difficulty. Such questioning and evaluating is valuable because it is in the service of determining the effectiveness of therapy, and of promoting ways to increase its effectiveness.

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A PATTERN OF NEUROSIS IN INDIA

ERNA M. HOCH

WHEN I was asked some time ago to contribute to this *Journal* a "short case study which shows the influence of individual, familial, and cultural factors in the development of emotional disorders," the great problem consisted in choosing a case from among my Indian patients in which the barriers of language had not been all too powerfully forbidding and in which, on the other hand, the influences of the West had not been too likely to overlay and disturb an original Indian pattern of life. I had to exclude all those patients I saw in regular psychotherapy over the first two or three years, since at the beginning of my psychiatric activity in the north of Indian, my rudimentary knowledge of Hindustani equipped me to deal only with people who were accustomed to express themselves in English. These, of course, are those who have also been most exposed to the cultural influences of the West. Although by now I can, if need be, communicate even with a simple villager in his own language without an interpreter, this usually is possible in only one or two interviews, as the patients often come from places hundreds of miles away and are neither psychologically nor economically prepared for a long course of treatment in the city. All they usually want is some "magic" cure for their ailments, and, within the short time available, our simple attempts to reveal some of the underlying emotional factors seldom can penetrate the thick, hard crust of customary beliefs, prejudices, and attitudes.

Recently, however, time and good luck played into my hands. A patient came to our clinic without a previous appointment who seemed to fulfill all the requirements for a case-study of this kind. He was a farmer from a village at the foot of the Himalayas, about 200 miles from Lucknow. He had been sent by the doctors of a Government hospital, where he had tried in vain to get help for his obviously neurotic symptoms. We found him sitting on the floor of our waiting-room, a tall, bony figure, dressed in village style, huddled in a big shawl. He had brought no money with him and probably had made the railway journey without a ticket. He had no idea what particular kind of clinic he had come to. So we had the advantage of examining him before he had had any chance to build up his defenses against a psychological approach. The interview, for which I used the Indian interpreter's help only when absolutely necessary in order to clarify some point, revealed a pattern of neurotic development I had had occasion to study thoroughly in some of my more westernized Indian patients, but which in this villager still seemed to exist in

Erna M. Hoch, M.D., Basel, Switzerland. Specialist's diploma in psychiatry of the "Foederatio Medicorum Helveticorum." 1950-1956 University Clinic and Policlinic of Psychiatry, Basel. Since 1956 Clinical Director of Nur Manzil Psychiatric Center, Lucknow, U. P., India.

its original Indian form, without any interference by western influences. The ready response of this man to my questions and attempts at interpretation showed me not only that the neurotic troubles of my more emancipated patients had an indigenous root and were not just western imports, but how easily even a simple farmer, who does not know a word of English, can grasp certain psychological truths if they are based on a sufficiently wide and open understanding of human nature and offered in terms that have meaning for him.

I shall first reproduce, as literally as possible, the interview with this thirty-five-year-old Hindu patient and then try to show the features common to other cases I have had an opportunity to observe and treat over many months.

During the physical examination we noted in the patient a leptosome-athletic constitution, rather dark-colored skin, slightly greying hair and, already at the age of 35, a typical arcus senilis corneae. The damp palms and jerky tendineous and periosteal reflexes betrayed some nervous tension. Otherwise we found no signs of physical disturbance, unless one considers the blood-pressure of 120/70 as rather on the high side for an Indian. The facial expression of the man can only be described as that of a "simple fool" in its best sense, i.e., of a man who has not been much touched by the complications and sophistications of life. A note of depression and anxiety was, however, unmistakable. His voice at times, particularly during the physical examination (a situation which often brings out regressive tendencies in our Indian patients), assumed a very childish note, which was in strange contrast with his big frame and clumsy movements.

The interview had best be given in the form of a dialogue: Doctor: "What is your trouble?" Patient: "My mind is bad." Doctor: "How does this express itself?" Patient: "I feel some giddiness. My eyesight is not clear. Often there is weakness in my whole body. This happens particularly whenever I try to do any work." Doctor: "What is your work?" Patient: "I am a farmer. I used to work in the fields." Doctor: "What do you do now?" Patient: "Nothing. I cannot work. I just lie all day." Doctor: "Do you get any fits?" Patient: "Yes, restlessness, anxiety, all just looks dark. There is heat in the whole body and the heart beats fast."

Doctor: "When did all this start?" Patient: "Four or five years ago." Doctor: "Who died at that time?" The interpreter, apparently shocked by this blunt question, tries to soften it down by asking, whether anyone died at that time. Doctor (repeating): "Who died at that time?" The patient's face first shows an expression of puzzled surprise, then breaks into a broad grin. He answers: "My father died five years ago." He states that his trouble started ten days after his father's death.

Doctor: "And you are the eldest in the family?" Again patient shows his surprise at this almost magic guess and, with the smile of a child caught in mischief, he answers: "Yes, I am the elder of two brothers." Doctor: "Are you married?" Patient: "Yes." Doctor: "Have you got children?" Patient: "No." Doctor: "Would you like to have some?" Patient: "Yes." Doctor: "Why don't you have any?" Patient: "First there was something wrong with my wife and now I am sick." We find out that there have been neither abortions nor children who died in early age. The marriage seems to be completely barren.

Doctor: "Is your brother married?" Patient: "Yes, he has one son. But brother lives separate since father's death."

Through the interpreter, we learned the following facts: When the younger brother saw the patient become ill after the father's death, he separated himself from the family, as he did not want to be saddled with the responsibility for looking after the brother in his illness.

Doctor: "What about your mother?" Patient: "She died twelve or fifteen years ago." Doctor: "What did father do?" Patient: "He was a farmer. He was strong and worked hard. He died at the age of

45-50." The patient's description of father's last illness suggests some heart insufficiency.

Doctor: "What did you do, while father was still alive?" Patient: "Then my brother also was in the family and worked in the fields. But I was the one to give the orders. Brother and servants did the work." Doctor: "Were you father's favorite?" Patient: "Yes, my father loved me very much and obeyed my orders and advice." Doctor: "What education did you have?" Patient: "I studied up to Hindi middle pass." Apparently he went to school late, and he only finished his six years of elementary schooling at the age of 20. Doctor: "So before father died, you never thought of the duties you would have to assume one day?" Patient: "No, I never thought what would happen."

Doctor: "What about the other relatives?" Patient: "Some of father's brothers are there. But they also do not bother about me. I actually think they are out to harm me. Father already had separated from his brothers in his lifetime. They are just the kind who want to profit." Doctor: "Is it perhaps that all these people might be jealous of the favors you got from father while he was still alive, and that now they take it out on you?" Patient: "Yes, I sometimes think it is like this."

Doctor: "How does your wife behave with you?" Patient: "She has a good disposition. But when I was still well, she gave me more love. When I refused to follow proper treatment and just took medicine occasionally, she began to lose patience and scolded me. Now she has gone to her family's home for her brother's wedding." Doctor: "Have you still had intercourse with her since you fell ill?" Patient: "Yes. I did not feel that it might harm me." We learn that he himself enjoys intercourse and that his wife does not mind it.

Doctor: "Do you see any connection between your trouble and your father's death?" Patient: "Yes, there may be something. The people who hold a share of my farm probably wanted to make me sick, so that they can get more out of me. About ten days after my father's death, I went to the house of my sister. In this same house live some female relatives of this shareholder. I had shorn my head, as it is the custom after a father's death. When I was there, I asked these people to rub some oil on my head. The relative of this shareholder rubbed my head with oil. There must have been some magic in it, and this spoiled my mind."

Doctor: "How do you get your living now?" Patient: I still have half the farm. But I have given it to some relative to cultivate and I just get half the crop." Doctor: "From what age onward did you have to work, when you were a boy?" Patient: "Up to the age of 20 I went to school. Then I started sitting in a cloth-shop which belonged to the joint family." (A typical Indian expression: a shopkeeper or shop-assistant does not "work" in his shop, but literally "sits," cross-legged, on a little platform, raised to the level of his standing customers.) "I continued to do this for six or seven years. Then father separated from his brothers. After that I also worked on the farm. But I only gave the orders and did not work myself." Doctor: "Does brother have less education than you?" Patient: "Yes." Doctor: "So the family placed all their high hopes on you?" Patient laughs and admits that they had some hopes for him. Doctor: "But if one wants to reach a high place, one cannot fly there. One has to climb step by step." Patient again smiles, nods his head pensively, admits that this is his trouble. Doctor: "Before, your family lifted you up into a high position on their shoulders. Now you ought to stand on your own legs and you do not feel strong enough?" Patient: "Yes, this is true."

Doctor: "What about religion? Which Gods do you worship?" Patient: "Bhagwan." Doctor: "What ideas do you have about Bhagwan? What sort of person is he?" Patient: "I think that if Bhagwan has put me into the world, he should also provide for my means of livelihood." Doctor: "So you rather expect God to do the same as your father? Before, you were father's child. Now you want to continue to be God's child?" Patient: "Yes, I still

want to continue to live as a child. But then God did not give me any children, so he did not make me a father." Doctor: "If you had had children, what would you have expected of them?" Patient: "That they should earn for me." Here patient again shows a broad grin, obviously surprised at our ready understanding of his thoughts.

Doctor: "How did your mother treat you?" Patient: "She loved me much." Doctor: "How long did you get milk from her breasts?" Patient: "I do not remember. Probably until brother was born, about two or three years. Then grandmother took me over." (From what the patient says it appears that, though he may not have got any milk, he at least was allowed to suckle his grandmother's breasts. This seems to be a fairly frequent pattern. On the other hand we have seen patients, usually the youngest in the family, who were breastfed by their mothers up to their tenth or even twelfth year of age.) Patient: "I was twelve years old when my mother died. About four or five years later, grandmother also died. Then father looked after me." Doctor: "At what age did you start taking your bath alone?" Patient: "At about ten or eleven years." Doctor: "With whom did you sleep?" Patient: "Mostly with grandmother, sometimes alone, sometimes with grandfather."

Doctor: "Do you have any dreams?" Patient: "Yes, quite a lot of them. Some are frightening, about ghosts, but some are quite pleasant."

Doctor: "How did you expect that we would help you?" Patient: "I thought it was a Government hospital." Doctor: "We mean, what method did you think we would apply?" Patient: "I have got too much heat in my body." As this can sometimes be a sign of vitamin deficiency, in particular a lack of nicotinamide, which seems to be exacerbated by smoking, we ask the patient, whether he smokes. We hear that he only smokes a little and that he takes no alcohol or other intoxicants, like *Cannabis indica* or opium, a possibility we always have to expect in examining our patients. Doctor: "Did you expect that God would perform a miracle through us?" Patient: "God should make my ideas right. I think that after my having served you, God will make me all right."

We now explain to the patient that medicines alone will not cure him. He will have to face his life-situation and work. No one can refuse to do what life asks of him without paying a heavy price. His symptoms are the price he pays for refusing to accept his grown-up responsibilities. The patient nods. He seems to understand.

Doctor: "If you feel you are too weak to start work in the fields right away, why don't you try to do some handicraft which takes less strength in the beginning?" The patient then explains that he belongs to a particular subcaste of the Vaish, which only allows him to do the farming. Doctor: "What about the cloth-shop?" Patient: "This no longer exists since father separated from the brothers. I sometimes buy a few medicines in the bazaar and sell them again to other people."

During the physical examination I had noticed a big, partly contracted scar on the patient's right forearm. As I could not understand the patient's first explanation of it, I now ask the interpreter to get the information for me. The patient explains to her that a picture of Hanuman (the monkey God, who helped Rama in his fight against Ravana's forces) had been tattooed on his arm.[1] When, after the father's death and the brother's leaving him, he had to do some of the farm-work himself, he felt that dirty, low matter such as the fodder which he had to mix for the cattle with his hands, should not touch this holy image. So he had it eradicated. Doctor: "It looks as if you had done the same thing with yourself: you did not want your nobler parts to touch the low everyday things of life, so you effaced yourself completely from your work?" At this the patient again grins over his whole face. We explain to him that both higher

and lower nature belong to life. If he neglects his lower nature, thinking that he is only born for high things, it will revenge itself by rebelling against him. The patient protests: "I want to work, but my illness does not allow me to work." Doctor: "What you call 'I' is not all of you. If in your country the Congress party, which is in power, decides something, this may not represent the will of all the people. There may be an opposition party, which rebels and causes trouble by strikes and riots." This is a simile which the patient readily understands.

Probably the patient will never come back to see us. Whether the few flashes of insight we were able to give him during a one-hour interview will be enough to effect any change in his attitude toward life is very doubtful. But as least he has furnished us, during his short visit, with a whole wealth of material on which we now want to base some more general considerations, illustrating them with samples from the case histories of our more permanent patients.

The easiest procedure will be to go through the case-history point by point, giving the necessary commentary to any phenomenon that is of interest.

The symptomatology of our patient will be familiar to any psychiatrist in the West: The vegetative symptoms of an acute anxiety attack, which, by and by, may be converted into a more permanent syndrome, such as the gastrocardiac symptom-complex, which we have frequently found in our patients. As in the West, many doctors here do not recognize that such symptoms are not a sign of weakness and exhaustion, but of an intense struggle between quite considerable energies. Instead of helping to release such energies, doctors often order rest, abstention from work and exercise; the patient submits, often only too willingly, but feels himself getting worse and worse. The continuing uncanny physical sensations stir up more anxiety, which in turn converts itself to physical symptoms, and the vicious circle is on its way. We have seen several patients who became completely incapacitated by such syndromes, losing the courage even to go alone from one room to another. On the physical plane the struggle between these energies seems to be one between the adrenergic and cholinergic, the sympathic and the parasympathic nervous systems. This, however, only seems to be the physical expression of a conflict that concerns human existence as a whole. The parasympathic system, with its function of rest, recuperation, and nutrition, seems to represent all those forces in human life that make for lethargy, stagnancy, passivity, for sinking back into the dragging mire of primitive matter, into the protective embrace of a nourishing mother. The sympathic, on the other hand, with its function of activity, of readiness for emergency and adventure, appears to be the physical exponent of all the human striving to rise out of the primitive mass, to emerge from anonymity into individual consciousness and responsibility. While the parasympathic system seems to have a feminine character of bearing, the sympathic represents masculine determination and aggression. In those patients, in which we watch these disharmonies of the vegetative nervous system, it appears, therefore, as if lower nature were at strife with higher human ambitions; the child, who calls for the mother, seems at war with the adult, who is eager to go out into life; the passive feminine principle resists the active masculine tendencies; in short, we seem to witness the age-old evolution of life in differentiating itself from

primeval mud, darkness, and lethargy, and becoming ever more refined, light, and spiritual. While at best this evolution is a harmonious growth, in which rest and activity, protection and exposition, bearing and fighting, all have their roles, each in its own time and place, it apparently can turn into strife and chaos under certain conditions.

Going back to our patient's case-history, we note that he complains of "heat in his head." This is a dread symptom among Indians. The old hygienic rules prescribe that the head should be kept "cool." For this purpose water or oil is poured on it when there is any sign of heat. Indian medicine lays great stress on the cooling or heating properties, not only of drugs, but of food. It is difficult to persuade an Indian to take some wholesome type of food, like curds in winter or tea in summer, as the one is supposed to be cooling, the other heating. It appears that this "heat" corresponds to some vital force, probably some repressed emotions or instincts, which should not be allowed to ascend into the head, the realm of cool, calm thought.

What is remarkable in our patient's account of his complaint is that, immediately, without knowing what a psychiatrist is, he explained that "his mind is bad." The word he uses for mind, of course, also designates "brain," but the meaning, though he later describes mainly physical symptoms, is plainly that something is wrong with his mind—as is also indicated toward the end of the interview when he explains that "God should make my ideas right." What modern psychosomatic medicine has discovered with much study and effort, namely, that one cannot separate body and mind, but must take a human being as a whole, apparently is still living knowledge with many Indians. In the Hindi language we get many expressions which show how natural it is for Indians to associate certain physical symptoms with a corresponding mental or emotional phenomenon. If one tries to differentiate whether a person who says "my heart does not feel like it" or "my liver is not doing its work" actually means the physical organ or some emotional disturbance, one often provokes only puzzlement, as a separation of the two has never been made in the patient's way of thinking. It is only the more emancipated, westernized Indian who takes his body as a scapegoat and insists that a certain symptom is plainly physical and cannot possibly have anything to do with his emotions.

Old Indian medicine had concepts about the origin of illness that modern psychosomatic theories can only envy. Certain theories maintain that any illness first enters the human being in the spiritual sphere. If not dealt with, it will advance from there into what is called "the subtle body." This is quite obviously a stage corresponding to what we call "functional." If the disease is not held up or eliminated at this point, it can penetrate into the material body, where it can cause irreparable damage.

It is my experience with this natural awareness of an indivisible psychosomatic entity in Indian people that gave me the boldness to face the patient with the blunt question: "Who died at the time you fell ill?" While the westernized Indian interpreter was shocked by it, the patient himself responded with an understanding grin and the prompt answer that his father died, which actually is what we had expected. Though the patient was already 30 years old at the time of this event, his father's death was very likely to play a decisive role in his life, par-

ticularly as he was the eldest son.

Without being able to give any accurate statistical figures, I can say from a rough estimate that "eldest sons" are quite disproportionately frequent among our patients. Being the eldest son in an Indian family, particularly if it is still a "joint family," means a childhood and adolescence in which all is appreciation, pampering, and glory without effort, whereas from the moment such a son has to take over the responsibilities for the family after the father's death, he has to lead a life of "action without the fruit of action."

Among my patients I have observed several men who, on their father's death, refused to subject themselves to the ceremony—in some communities the shaving of the head, in others the putting on of a special turban—by which they were to become head of the family. They had to pay for their refusal by psychosomatic symptoms or paranoid syndromes. On the other hand, we have seen men who never were called into an active role at all, if their fathers happened to live to a great age. By the time they had to succeed the father, they had grown-up sons to whom they could hand on the management of the family affairs. At any rate, there often seems to be no proportion between the early upbringing of an eldest son and the responsibilities he has to face in later life. While in the West a young man has to prove his manhood by gaining the appreciation of a female partner and by being able to provide for her, the young Indian is often married automatically at a very early age, perhaps while he is still a college student, unable to assume any economic responsibility. Often the begetting of a child is the only proof he can give of his manhood, and we have seen quite a number of children who quite obviously had come into the world merely as an advertisement of their father's masculine powers. That an act of this kind is by no means sufficient to convince the father very deeply or lastingly of his manhood is shown by one of our neurotic patients who, at the age of 42, is the father of eight children. When recently we asked this man on which occasion he had first felt that he was a man, he replied that at the age of 21 or so one usually thinks of oneself as a man. I then pointed out that I did not want to know when he thought he was a man, but when he felt like one. To this the patient reacted with an amused smile, and with an honesty that is the result of two-and-a-half years' hard psychotherapeutic work, he answered that he had never yet felt himself to be a real man.

Sometimes one sees a young man make an effort at emancipation during his years of adolescence. But often marriage merely means a return to the realm of the mother. As we see later in our patient's history, the children often are regarded only as investments for the future. One of our patients, a man who had aged prematurely and who, at about 45, was already showing distinct signs of cerebral arteriosclerosis, demonstrated this expecting parental attitude very impressively. He once brought his youngest son, a miserable looking little chap of five. While one would have expected the unfortunate father to complain that he would not be able to provide for this child up to his adult age, he instead pointed out regretfully that he would never live to see the day when this son would provide for him.

In the old joint family, in which several generations of relatives live and work together, contributing to and drawing from a joint income, the immaturity and dependency of any in-

dividual family member may never become an open problem. But the breaking up of joint families into smaller family units is likely to expose any lack of independence and wholeness. We do not quite know what precipitated the breaking up of our patient's family. Possibly it may have been some factor that had nothing to do with India's westernization. The small number of sons in the patient's generation and the barrenness of the patient's own marriage make one suspect that there may have been some process of biological degeneration in the family. There may not have been enough people in the joint family to distribute the load comfortably and to make the advantages of common life outweigh the drawbacks. Where western influences have had more effect, the disintegration of the joint family is a very frequent phenomenon.[2, 3]

The social and economic changes in modern India call for emancipation and independence of the individual who, up to now, has been safely sheltered in the collective order of life in a joint family, caste, and religious community. In this symbiotic way of living many people have never developed into anything like individual wholeness, but cultivated only one particular function, and relied on other, equally specialized people for all other functions. The caste system, in fact, seems to be built upon the idea that human beings are born for one particular function, that of the priest and teacher, the warrior, the merchant, and, finally, that of the artisan and laborer. As we see later in our patient's history, these caste taboos still function very efficiently even in modern India, in spite of legislation to abolish caste distinctions: our patient considers it as below his dignity to touch any craft. One can imagine that such limitations can be rather a problem in occupational therapy and in the rehabilitation of mental patients, particularly in dealing with mentally deficient or brain-damaged children. Centuries of specialization have not only cultivated firmly rooted prejudices, but often lead to atrophy or, at least, degeneration of certain human possibilities in members of very exclusive castes. If such people now are supposed to step out of their collective way of life into individual wholeness, they are often like invalids with amputated limbs, once the customary supports fall away.

I do not think that the West has much reason to look down on this lack of individual development in the Indian, who is emerging from his collective order of life. Once one's eyes have been opened to such problems, one also can see them in western patients, although perhaps disguised by factors which we in the West take for granted and therefore never question. The European and American patients we occasionally see here often suffer for the very reason that in this foreign country they are without their customary supports. They may first try desperately to constellate their new surroundings into something resembling their home conditions. If this is impossible, they have to realize their own lack of wholeness, which often means a physical or emotional breakdown.

In our patient's case we see that, considering his caste and his position as the eldest in the family, he regarded it as his special function only to supervise the work on his farm—literally only to be the "head" of the economic unit. Any other function was below his dignity. This, of course, meant an enormous inflation of his "higher nature," while his "lower nature" was despised and suppressed. Although, again, such phenomena are not unknown in the

West, Indians are perhaps a bit more in danger of becoming a prey to them. While in the West the position a man gains in his work is more or less determined by his actual capacities, there are many ways in India by which a man can get into a post for which he is not really fit. Family prestige, good connections, the demands of his caste can promote a man into a position which he could never keep up on his own strength. Naturally, such a situation is very perilous and provokes anxiety and insecurity. The inflation necessary for keeping it up often expresses itself in the physical symptoms of aerophagia, frequent belching, gastro-cardiac disturbances.

This is illustrated by a dream of one of my psychotherapy patients, who, after his childhood as a village boy, had been carried high in life through various fortunate coincidences, but who actually had never developed in himself the strength and maturity to keep up his position. On the contrary, he is the same person who confessed at the age of 42 that he had never yet felt like a man in his life, who, in fact, depended on his wife and his doctor like a small baby on his mother. After about two years' psychotherapy, this patient, A., produced the following dream: He is at about the age of 14. Some games are going on at B., the place where he used to go to school. He goes to the playground to see the games, then goes to the horse races. When he reaches there, he finds that the races are over. Some other games are going on, and he sees and enjoys them. Then a boy, about six or seven years old and very handsome, takes one of those paper balloons that one makes rise on festivals by lighting a fire inside them. The boy sits in it and flies in the air with it. There is a light burning in the balloon to guide the boy. The patient sees it all with much interest. After some time he finds that the balloon is coming toward him. It starts coming down and strikes against the patient. He also takes a balloon, sits in it, and begins to fly. The balloon is closed above him; it is red-yellow in color. Then someone puts bricks on top of the balloon, so it has to come down. It is difficult for him to come out of the balloon. There is a load of bricks on all the sides. After a time, someone takes off the bricks. Then he goes to the house of a friend, who is also about 14. They are sitting in a room. Suddenly J., a friend from High School (it may be significant that this friend has the same name as a member of the therapy group the patient attends; this group member is a much more active young man who shoulders his considerable responsibilities quite willingly) puts bricks on the patient's head as a joke and makes him walk about with this load. (This is actually the way in which Indian workmen carry bricks when building a house). At this time he is a heart patient. He begins to scold his friend for making mischief, although he is obviously a heart patient. In his dream the patient begins to breathe hard.

This same patient, apart from having been pampered by an overprotective mother in childhood and from having been carried on the wings of good fortune up to the age of 35, had made contact with some religious Ashram at the age of 20. He developed aspirations toward saintliness and imagined that he had completely overcome his lower nature. Later he had to admit that his religious teachers, followers of Shri Aurobindo of Pondicherry, had always warned him against wanting to "draw down" the spiritual forces prematurely, as the first task in religious exercises is to widen the base

for receiving "the force." After about two-and-a-half years of psychotherapy, he realized that he had committed a serious mistake by thinking he could neglect these warnings.

This example shows that it is the misuse and misunderstanding of religious practices which is responsible for certain neurotic disturbances, but not the religious precepts themselves. There is, in fact, hardly any discovery of modern western psychotherapy that cannot quite easily be confirmed by some precept, parable, or proverb from the old sacred writings of Indian religions.[4] As I have become more familiar with Indian religious tradition, I find it quite easy to explain western psychological ideas to my patients in terms of their own religious literature or folklore. Often no new concepts have to be introduced at all. One merely has to clear up misunderstandings about their own traditional Indian teachings, which, like any religion, have become overgrown with superfluous, spurious, and distorted elaborations in the course of time.

Some misconception of Hindu religion is obviously also at work when our patient, to jump ahead in his history, gives his view of God, Bhagwan, as a universal provider who owes him his livelihood, once he has brought him into the world. Our patient, like so many other Indians who, in their own childishness, can see in God nothing but a great father or mother, forgets that the highest Godhead, whom he calls Bhagwan, is usually presented in three aspects: the Creator, the Preserver, and the Destroyer. Destruction, or change, is considered as necessary if life is to be kept up. If this were not proof enough that stagnation in a childishly passive attitude is no true religious ideal, one would only have to point to the famous discourse on action and contemplation which Krishna gives to Arjuna in the Bhagavad-Gita,[5] culminating in the often quoted command, "To do is thy duty," or the explanation that "the way to contemplation lies in action." But although some of the highest formulations of Hinduism regard action, change, and even aggression and destruction as necessary elements of life, one all too often observes in Indians an attitude of passivity, resignation, or fatalism, which finds appropriate expression in the Hindi proverb: "If you get your bread, why should you bother to cultivate your field?" This idea seems to be in the mind of our patient when he leaves his fields to be cultivated by a relative. Although in this way he gets only half the crop, it is worth being relieved from making any effort himself.

If one comes from a northern country, in which storing and hoarding for the long winter is a necessity, one wonders whether this attitude may be partly the result of climatic conditions. If two yearly crops can be reaped, there is no necessity to provide for a long period of time. One can rely more or less on a hand-to-mouth existence. On the other hand, however, it is probably not only this security of a bountiful nature, which also seems to be at the root of the "dolce far niente" of South Europeans, but just as much the insecurity of life which prevents people from thinking ahead and hoarding. If one realizes that even nowadays millions of dollars in economic values and thousands of human lives are destroyed each year through floods, drought, storms, and other catastrophes, and that, furthermore, in the villages human life is never secure from epidemics, "dacoits" (gangs of robbers and murderers), and wild animals, one begins to understand the Indian's fatalism, his tendency to live and rely on

as little as possible of one's worldly belongings, since any attachment will only mean disappointment and bereavement, sooner or later.

Even if these forces of nature were no obstacle to assembling wealth, prosperity and progress might still be dangerous things, as they would attract the jealousy of one's neighbors or of evil spirits. Our patient plainly admits that he feared the jealousy of his relatives with regard to his privileged position in the family. We have frequently heard such ideas, even from our more westernized patients: It is dangerous to become prosperous or even healthy in life. Other people, particularly women, will become jealous and try to cause one's downfall. This can be done by various acts of "djadu"—magic. In our patient's case, we see that he suspected some magic influence in the rubbing of his head with oil by a person who had reason to envy him. One must know that among primitive people[6] the head is supposed to be inhabited by a particularly sensitive and delicate "spirit" that resents any unauthorized touch. This probably is the reason why the first cutting of the hair of a small boy has to be performed as a religious ceremony under many precautions for his safety. Having had his head rubbed by a person who entertained some jealousy and evil intentions was very likely to expose our patient to some magic influence, which then made his mind "bad." In other cases the magic is supposed to be conveyed by food or drink, or simply by the "evil eye," usually of a woman. It is clear that the persistence of such magic beliefs is a very fertile basis for paranoid developments. Quite generally, the less-emancipated Indian still regards his fate very much as something determined by forces outside him. He has not learned yet to rely on his own ability to take charge of his life. Even in the old epics, like the Ramayana,[1] one often sees that a hero only succeeds in killing some monster if the fatal day for the monster has come anyway. He is only the executioner; the judgment has been spoken long ago by the Gods or the stars. Several of my psychotherapy patients, two of them medical students in their last year, were much more likely to believe that psychotherapy had helped them because some improvement had been predicted by their horoscopes than to trust the forces that had been developed within them.

The actual root of this fear of jealousy probably is the unconscious awareness that one does not owe one's ascent to high position and prosperity to one's own forces, that one has to depend on others for one's status and that without their good will one will not be able to maintain it. At the same time, it probably represents the anxiety about being exposed by having grown, in some way or other, beyond the common level of one's surroundings and having lost, perhaps through one's inflation and contempt for lower nature, one's roots in the common ground of humanity. The warning, dragging, or rebelling of one's own more earthly, but also more primitive, childish levels against a precipitated rise without a sufficient basis is experienced as coming from outside in the form of jealousy, ill-will, lack of cooperation on the part of those who represent these lower forces, particularly women, who, either in waking life or in dreams, are seen as cunning witches.

This fear of jealousy, together with the wish to escape the excessive claims of others on one's wealth and energy, can be a reason why a man not only avoids accumulating possessions, but also why he may renounce the use of

his own energies. One of our patients, a student, resented the fact that his fellow students never returned the books he lent to them. He shut up all his books in a box and carefully hid it so that no one should know about them and consequently not ask for them. It is needless to say that in this way he also greatly handicapped his own progress by cutting himself away from resources for his studies. In the same manner the 42-year-old patient A., whom we have already mentioned several times, seemed to be unconsciously out to conceal his energies, to pose as a weak man subject to heart attacks, because in his sensitivity—and also out of false pride and a wish for prestige as a philanthropist—he felt unable to refuse claims for help, which would have been a natural consequence, if he had been able to keep up his favored position in life.

What rather surprised us in our patient was that, in spite of his illness, he apparently had not given up sexual intercourse. Perhaps the reason for this was that the many years of barren marriage had sufficiently assured him that he did not risk conception, or, on the other hand, possibly his seeing any potential children only as a future asset. In many of our Indian patients the idea of sexual intercourse is still closely or even exclusively associated with that of reproduction. On the other hand, there is a widespread belief, usually based on some wrongly understood religious principles, that any loss of semen, whether in rightful intercourse or in some solitary practice, causes a loss of strength, which should be avoided. Many of the yogic exercises are meant to direct this precious seminal fluid upward and to transform it into spiritual energies. Although in certain other forms of Hinduism the merging of the male and female principle is often represented in a very obviously sensual embrace of a God with his female "Shakti," indicating that the sexual act is also valued as a symbol of a higher union, we very seldom find such ideas realized in Indian marriages. In this respect again, "lower nature" is eliminated by suppression rather than by acceptance and transformation into higher energies. Often sex is never integrated into total personality, but only treated as an awkward, embarrassing concession to lower nature. If, at the age of 45-50, men try to be true to the Hindu ideal of the four Ashramas (the four ages of life, according to which a man spends his first 25 years in chastity, preparing himself for his adult responsibilities; the next 25 years as a father, householder and professional man; the years from 50 to 75 in gradual withdrawal from worldly life, although still remaining with the family; and the last portion of his life in meditation in the jungles or mountains, away from civilization), the forced cessation of sexual activities, which have never been built harmoniously into the total personality, may cause serious nervous trouble. The inhibited attitude which Indians, particularly Hindus, have with regard to sex also shows itself in the fact that in Hindi and Hindustani there is no proper term for "sexual intercourse." Either one has to describe the act by a term that simply means "to do work," or one can talk about "the conversation" or "the speaking" that goes on between husband and wife. One wonders whether the frequent symptoms of displacement to oral mechanisms, in particular to the functioning of the tongue, which one finds in Indian neurotics, may have some connection with these euphemistic verbal references to the sex act.

In our patient it looks as if his whole

nature still had been so infantile that he had not even developed any significant inhibitions with regard to the sex act. Often one gets the impression in such neurotics that the wife is approached more as a comforting mother than as a proper sex partner. If one considers that a boy sometimes may have been breast-fed up to the age of 10 or 12 and that he gets married at the age of 18 or even earlier, there is little time in between in which he could free himself to become a mature male. It is much more likely that closeness to a woman in the conjugal bed will put him back to the time—perhaps only four or five years back—when he slept cuddled up to his mother or grandmother. On the other hand, many Indian women, married before they are mature and burdened with children before they ever wake up to any personal interest in sex, never discover that physical union can also be a source of female pleasure and satisfaction, and not only a conventional duty. One can imagine that such immature women do not have much emotional security to hand on to their children. We find that the act of breastfeeding or, later, of giving food to the child is often the only way in which a young mother can prove her affection for the child or appease her guilt-feelings with regard to some unconscious rejection of the child. Stopping a psychotic or depressed young mother from breastfeeding her child because one fears the effect of some medication on the child can have far more disastrous consequences than the risk of a little sleepiness through some sedatives which reach the child through the milk. As the feeding of a child is such an important expression of affection, refusal of food can be a very effective means for showing hostility and protest, and for making the rejected offerer of the food feel guilty. Probably many of the hunger strikes that are used to enforce political, social, and economic demands go back to such roots. It would lead too far in this connection to discuss all the symbolic meanings that food can have for Indians, and that can be traced in numerous idioms of the Indian languages.

There was neither time nor the occasion to learn much about the dreams of our patient. Perhaps a few dreams of other patients with similar symptoms and etiology, whom I have seen in psychotherapy over a long time, may reveal some symbols of the conflict of forces that goes on under the protective covering of the handicapping symptoms. In the 42-year-old patient A., whom I have already mentioned, we observed the development of such symbols during his treatment.

In one of his first dreams he was followed by a lion from which he fled to the top of his roof, leaving his neighbors to deal with it. About eighteen months later, he dreamt about a big snake, which he and some other people had to bury somewhere. The patient admitted that they were not quite sure whether the snake was dead. The fact that they buried it and did not burn it meant that they allowed for the possibility that it might come to life again. At that time it dawned on the patient, who had imagined himself to be a very saintly, spiritually advanced person, that he had not really given up his lower nature, but only suppressed it, and that the solution would lie in accepting and transforming it. In a later dream an ambitious, boastfully inflated politician died in the patient's house. Among the people who were to carry away the body, the patient noticed a robust young village lad. The patient scolded him because his loincloth was wet and thus exposed

the shape of his genitals through the clinging material. "Lower nature," which the patient had at least partly accepted during his childhood and adolescence as a village boy, had now become humanized, but still was not considered as presentable, but rather a spot of shame.

Dreams of such patients,[4] except for the fact that the choice of symbols is perhaps somewhat determined by local phenomena, differ not at all from the dreams of equivalent western patients. As in the West, they can be used as one of the principal, more convincing sources for helping the patient to open himself up to more of his life possibilities. On the other hand, of course, we find in our Hindu patients other opportunities for symbolic expression through Gods, demons, and other figures of religion and folklore.

In our patient, the figure of Hanuman[1] plays a role. He has effaced Hanuman's tattooed image on his arm, so that it should not be contaminated by the low matter the patient had to touch in his farm work. Hanuman, always represented with a monkey face and tail, but often also with two wings, is a rather fascinating figure. He is generally regarded as symbolizing chastity and devotion to duty. On watching the monkeys at their mischievous play, one is puzzled that an animal apparently anything but chaste should have been chosen to symbolize this virtue. But on reflecting further, one realizes that this figure expresses a deep truth. Like the crusading knights and minstrels of the Middle Ages, he personifies male virtue, which, inspired by a fair lady, braves a long series of deprivations and temptations and performs many heroic deeds to save her from a monster. On the other hand, Hanuman seems to be related to such figures as Hermes or Mercury in antique mythology. As Hermes, Hanuman is the messenger between the realm of the Gods and the underworld. He moves with great leaps, helped by his wings, from the snowy heights of the Himalayas, the seat of the Gods, down to the dark realm of the Rakshasas, the demons, in the island of Ianka (Ceylon). Hanuman seems to symbolize the forces of ego-development, of conscious control over man's animal nature and his spiritual aspirations. Hanuman, therefore, is particularly apt to serve as an ego-ideal for adolescents. He exhorts them not to settle down in comfort, but to aspire to higher forms of satisfaction, to venture out into the fight of life, to postpone the gratifications of their desires until they have proved themselves worthy of them. In short, he seems to be a representative of true human striving which coordinates the lowest and the highest in human nature into harmonious growth.

At the moment when a man follows his infantile tendencies, goes back to the mother, and renounces any further advance in life, Hanuman naturally becomes an awkward warning. Our patient probably did not efface his picture so much because he was afraid of desecrating his image by touching low matter, but because the sight of this valiant hero and conqueror of dark forces on his arm would have been a constant and unpleasant challenge to the man in him. It is fascinating to see how frequently the dark, lethargic forces in man succeed in disguising themselves in seemingly high spiritual aims to achieve their purpose of pulling the victim down into their realm. Many compulsive syndromes, which here in India often go undetected for a long time[3] because they are simply regarded as expressions of particularly conscientious religious practice, quite obviously have the purpose of protect-

ing the patient from his daily duties by engaging him in some pseudo-activity, which keeps his conscience appeased.

This failure to face life as it offers itself, of not assuming one's responsibilities and not developing one's possibilities, seems to be the most universal factor in any neurosis or, ultimately, perhaps in any kind of disease. Even certain religious practices only represent a compromise, an act of buying oneself off from accepting life by offering to the Gods a small part of one's time and efforts, while one claims the rest of one's life for oneself, one's own comforts, one's own aims. In this respect again one of the dreams of our psychotherapy patient A. gives a very fitting illustration.

At the end of his second year of psychotherapy, he dreamed that he was going to the river Jumna to take his sacred bath. He went to a ghat (a bathing place, usually associated with a temple) where there were no other people, since he wanted to bathe with the help of a lotah (a brass jar used for ablutions) because he was afraid of dipping into the river. Any Indian will quickly agree that a river is a very apt symbol for life. Without the big rivers, life on the huge plain of North India would be unthinkable. In some communities small boys are taken to the river, preferably the Ganges, thrown into it by a priest and then, after having been ducked backward and forward a few times, handed back to the parents as a gift from the river. This ceremony was performed on A. in his childhood and he has retained quite vivid memories of it. He knows that the daily sacred bath in the river in some way symbolizes one's acceptance of life. In his dream, however, he is afraid of throwing himself into the stream without reserve. He plans to remain on the shore and pour the water over himself with his lotah, so that he can choose where, when, and with what force the water should touch him. At the same time he is ashamed of this unmanly, cowardly behavior and has to choose a place where no one will see him, just as the neurotic who makes his own conditions for accepting life also has to deal with his feelings of guilt and shame, which may lead to withdrawal and concealed living.

Another patient, a middle-aged man with depressive symptoms, experienced the challenge of the unlived life in an equally impressive dream. He saw three Buddhist monks sitting in a cross-legged position—the attitude of religious meditation—each on a high bamboo pole. Around the poles some bees are buzzing and humming in excited flight. The monks find themselves in a dilemma. Either they have to become so insensitive and detached to all that is going on around them that they no longer are disturbed by the buzzing bees, even if they should attempt to sting, or they must risk losing their precarious balance on top of the pole by taking some action to drive them away. The patient agreed that the best solution for them would be to come down to earth and to deal with the situation there. He also realized that where there are bees, there might be some honey to gain.

Our patient from the village seemed to understand our hints that his trouble lay in not accepting his life situation. But will he find the courage and the strength to apply this knowledge? One of the awkward barriers in utilizing any insight gained during psychotherapy seems to be embarrassment and shame in facing the loss of prestige that might be associated with giving up one's symptoms and any attitudes associated with them. We often found this problem a very power-

ful factor in the perpetuation of hysterical symptoms—some outburst of excitement and violence in a village woman whose life has been too much narrowed by convention. In such cases we have to try to build a bridge to help the patient to "save face." Sometimes the mere fact that the patient has consulted a foreign doctor, in whose magic powers not only the patient himself, but also his relatives and neighbors will believe, provides a sufficient excuse for giving up some symptom. It is quite possible that for our patient his journey to the faraway city and the discussion with the European lady-doctor may carry enough weight to help him to discard his symptoms and his inactivity, which have become rather embarrassing, since they cause him more inconvenience than not.

The satisfaction of such primitive needs for prestige, which is probably one of the main psychological factors on which many quacks and magicians rely, is something we have to respect in our treatment, in particular in "short psychotherapy." We have to meet the patient on a level at which he can understand our efforts. This may also mean that we have to give in to the patient's need for punishment, as he may not be mature enough to see the expiation of some guilt in his acceptance of the very life situation he has been refusing or avoiding. Often patients request us to give them ECT, seeing in this procedure either a magic trick or some act of punishment. We have, however, found out that more indifferent, less destructive methods, as long as they are associated with some pain and discomfort—as, for instance, the intradermal injection of distilled water—may serve the same purpose.

In those patients who are educated and mature enough to agree to prolonged psychotherapy, aims and methods do not differ much from psychotherapy in any other country. Perhaps one has to be conscious of the fact that, in general, Indians are more childlike and often more sensitive than western people. They have a very delicate sensorium for registering any fine shading of mood and emotion in others and for communicating emotions to each other without verbal expression. This openness to a common human ground, in which perhaps only very small children can participate any longer in the West, can be very helpful in psychotherapy, particularly with schizophrenics. But on the other hand, it demands of the psychotherapist great integrity, honesty, and a renunciation of all pomp and make-believe, such as a merely "therapeutic attitude" which is not supported by genuine interest and truly human understanding. Any pretentiousness would immediately be sensed by the patient and prevent him from being sincere, too.

One also has to keep in mind that what causes the breakdown of many Indians in this phase of their country's social and economic change is a tendency to force the emergence of the individual too precipitately, together with an enormous overestimation of intellectual factors. Under these circumstances, one has to be particularly careful not to want to make, as one of my Indian colleagues expressed it, too much "headway" in therapy, but to create the permissive, relaxed atmosphere of motherly forebearance in which the patient will feel encouraged to give up his ambitious forward-and-upward urge and consent to turn back toward those possibilities of his life which have been left behind as unacceptable, useless, and hampering. Instead of perfection in a limited sector and on too small a base, we have to teach our patients to accept complete-

ness, wholeness, all that is implied in the word "health"—if we consider its common root with "whole" and "hale."

Even this concept of "health" can easily be expressed in Hindi. The word for healthy, "swasth," is derived from the root "swa-" which means "self, own, proper," while the suffix "-sth" designates that something is resident, standing, present. Consequently a person is "swasth," healthy, if he is able to stand in and on himself, if he has assembled within himself all the possibilities given to a human being, neither having lost himself to the outside world, nor having inflated himself with parts that do not belong to his true self. But this, to a Hindu who knows his religious teachings, will at the same time lead to a further step. This self, "swa-", is the same as the "Atman," which is a spark of the "Brahman," the Divine. Acceptance of one's life as an independent individual does not lead to proud isolation, but links one up with the whole creation, no longer on a primitive, symbiotic base, but on a conscious level of freely chosen responsibility and reverence for all that lives and grows out of the common divine ground.

Summary

The case-history of a 35-year-old Indian farmer, who has had hardly any contact with western influences, and who, after the death of his father, developed an anxiety-neurosis with gastrocardiac symptoms, demonstrates some of the cultural influences contributing to the formation of this particular pattern of neurosis in India.

The vegetative-nervous symptomatology in such cases seems to represent a struggle between those forces in life which make for lethargy, stagnation, passivity, and degression and those which represent activity, readiness for emergency, and human striving to rise out of the mass into individual consciousness and responsibility.

In unsophisticated Indian patients one still can find a quite natural awareness of "psychosomatic wholeness," which often enables them to grasp very readily the relationship between some physical symptom and an underlying emotional problem.

One of the factors that contributes to the development of neurotic patterns is the frequent disproportion between the way a child, in particular an eldest son, is brought up, and the difficulties and responsibilities he may have to face in later life. The system of arranged marriages often forces young people into a situation for which they are neither emotionally, socially, nor economically mature. Up to now such immature young husbands and wives have found shelter in the joint family; nowadays the breaking up of such family units into small individual families often exposes the lack of independence and individual wholeness. The caste system, too, is often likely to force a man into a position or occupation for which he is not adequately fitted.

While many of the religious teachings of Hinduism can be valuable guides for mental hygiene and spiritual development, their misinterpretation and misuse can lead to various types of emotional tension or to a lethargic fatalism. The latter is also favored by certain climatic factors. Furthermore, the fear of the neighbors' jealousy and of evil spirits may prevent a man from accumulating wealth or even from exposing his physical strength.

Some of the prejudices and practices concerning the sex life are particularly likely to create tension in men, as well as in women.

Dreams of Indian patients do not

differ much from those of western patients and can readily be used in therapy. On the other hand, Indian mythology and folklore provide an additional opportunity for symbolic expression. Religious practices often seem to have a similar meaning, as do compulsive symptoms: to relieve and justify the patient in not facing his daily duties by keeping him engaged in some pseudo-activity, which will appease his conscience.

Just understanding that neurotic problems may represent an escape from accepting life as it is does not supply the patient with the necessary strength for implementing his insight. Often, particularly in "short therapy," it is necessary to "build a bridge" by some suggestive therapeutic method to help the patient face the embarrassment, shame, and loss of prestige that might be associated with giving up a symptom too quickly.

The patients who are willing to undergo prolonged psychotherapy usually are the more westernized ones. Even in them one has to take account of the fact that Indians are generally more childlike, more sensitive, and more gifted with emotional empathy than western people of equal social status. On the other hand, the present phase of cultural transition is associated with an enormous overestimation of intellectual values. Psychotherapy has to take account of all these factors. The Hindi concept of health, which has the meaning of "self-supporting" and "self-reliant," is a worthy aim of psychotherapy, provided one keeps in mind that this very "self" is a spark of the Divine, which links the individual with the whole of creation on a conscious level of free choice and responsibility.

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DIALOGUE AND THE "ESSENTIAL WE"

THE BASES OF VALUES IN THE PHILOSOPHY OF MARTIN BUBER

MAURICE FRIEDMAN*

THE BASES of values in Martin Buber's thought are his philosophy of dialogue and his philosophical anthropology, or the study of the problem of man. On this twofold foundation he establishes such basic value categories as the distinction between "I-Thou" and "I-It" relationships and that between "dialogue" and "monologue," the responsibility of the whole person to meet and respond to what addresses him in the "lived concrete," the primacy of the dialogical over the psychological, confirmation and "imagining the real," genuine speech and the "essential We," the distinction between "existential guilt" and neurotic guilt-feelings. These categories can help illuminate the value problems that arise in group psychotherapy and that are central to the goal and direction of such therapy.

"I-THOU" AND "I-IT"

Martin Buber's philosophy of dialogue is best known through its classic presentation in his little book *I and Thou,* the second edition of which, including an important new postscript by Buber, was published by Scribner's in 1958. In this book Buber makes his now famous distinction between the two relationships or basic attitudes that constitute human existence: the "I-Thou" and the "I-It." What distinguishes these relationships is not the object of the relation, but the nature of the relationship itself and the difference between the "I" that enters into the one relationship and the "I" that enters into the other. The "I-Thou" relation is direct, mutual, present. In it the other person is related to in his uniqueness and for himself, and not in terms of his relations to other things. In an "I-Thou" relation my partner reveals himself to me directly, as just the person he is. I do not seek for his meaning by enregistering him in one or another general category. In the "I-It" relationship, on the other hand, the other is my object and not my partner. I observe him and use him; I establish his relation to this or that general category. I know him with the same detachment that I know any object, or I see him purely in emotional terms, but, in either case,

*Professor of Philosophy, Sarah Lawrence College; lecturer, The Washington School of Psychiatry; lecturer, The New School for Social Research (New York); guest lecturer, The William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology; author of the first comprehensive study of Martin Buber's thought, *Martin Buber: The Life of Dialogue,* the University of Chicago Press, 1955; Harper's Torchbooks, 1960.

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not as a really independent person standing over against me. Hence this relationship is never really direct or mutual or truly present. In the "I-Thou" relation the whole person enters. Here emotion and reason, intuition and sensation are included in the wholeness of the person responding to what he meets. The "I" of the "I-It" relationship, in contrast, is always partial, and it is just as much "I-It" if it is emotional as if it is rational, if it is subjective as if it is objective.

Both "I-Thou" and "I-It" are necessary for human exstence. "I-It" again and again provides the base for ordered civilization, for technical accomplishment, for scientific advance. Yet "I-It" is not sufficient for human existence even on the barest terms. Without the "I-Thou" relation, the biological human individual would not become a person, a self, an "I" at all. He begins with the "I-Thou" in his relation to his mother and family, and only later develops the separating relationship of "I-It." As long as the "I-Thou" and the "I-It" remain in healthy alternation, ever new material from the realms of the physical, the biological, the psychological, and the social is brought into the "I-Thou" relation and given new, present meaning. When "I-It" becomes predominant and prevents the return to the Thou, however, man loses authentic existence and ultimately falls into pathological self-contradiction. Thus, Buber's "I-Thou" philosophy is both descriptive *and* normative, fact and value. The normative comes in in the difference between mere existence and authentic existence, between being human at all and being more fully human, between holding the fragments of the self together sufficiently to get by and bringing the conflicting parts of oneself into an active unity, between having partial, disparate relations with others and having fuller, more responsible ones.

The Life of Dialogue

In *Between Man and Man,* Buber expresses his basic distinction in terms of the contrast between "dialogue" and "monologue." Dialogue may be silent and monologue spoken. What really matters in genuine dialogue is my acceptance of the "otherness" of the other person, my willingness to listen to him and respond to his address. In monologue, in contrast, I only allow the other to exist as a content of my experience. Not only do I see him primarily in terms of his social class, his color, his religion, his I.Q. or character neurosis, I do not even leave myself open to him as a person at all.

Values as a philosophical or idealistic abstraction fill the air of the world of "It" and are often, in fact, the favorite subject matter of those given to monologue, whether it be the principles they expound, the code by which they live, or the "moral" standards by which they judge others. Values as a living human reality, however, only exist in the "life of dialogue," in the direct, reciprocal relation between man and man, for in it alone are we able to know and respond to the other in his uniqueness. "The life of dialogue is not one in which you have much to do with men, but one in which you really have to do with those with whom you have to do." And it is only when I "really have to do" with the other that I can really be responsible to him. "The idea of responsibility is to be brought back from the province of specialized ethics, of an 'ought' that swings free in the air, into that of lived life. Genuine responsibility exists only where there is real responding."[1] Responsibility, to Buber, means the response of the whole person to what

addresses him in the "lived concrete" —his full concrete situation. No abstract code is valid in advance of particular situations. None has universal validity, because value does not exist in the universal at all, but in the particular, the concrete, the "interhuman." This does not mean that moral codes are of no use if they are recognized as what they are—abstractions, generalizations, rules of thumb that may be helpful in pointing us back to the concrete values that men have discovered in real meeting. But they cannot take the place of our discovering for ourselves, each time anew, what is the right direction in a particular situation. The movement of values, therefore, is from the concrete situation and the deep-seated attitudes which one brings to that situation to the response and decision that produce the moral action.

"No responsible person remains a stranger to norms. But the command inherent in a genuine norm never becomes a maxim and the fulfillment of it never a habit. Any command that a great character takes to himself in the course of his development . . . remains latent in a basic layer of his substance until it reveals itself to him in a concrete way . . . whenever a situation arises which demands of him a solution of which till then he had perhaps no idea. Even the most universal norm will at times be recognized only in a very special situation. . . . In moments like these the command addresses us really in the second person, and the Thou in it is no one else but one's own self. Maxims command only the third person, the each and the none."[2]

The "ought" which arises in the concrete situation is not the pure "I-Thou," but what Buber calls the *quantum satis*—the sufficient amount of what one can do in that hour and in that situation. Just because real values arise in the concrete situation and in terms of the particular person confronted with that situation, the "ought" must include and be based on the real concrete person and all the limitations and resources that he brings with him into the situation.

This is not a question of free will vs. determinism. With the exception of some types of psychotics, everyone is subject to all kinds of conditioning that he brings with him into the new situation, yet everyone has some measure of freedom of response which is more than mere conditioned reaction. The real problem is discovering what is the actual point and moment of freedom in any particular situation, what is the real possibility of awareness and response. But this can never be done by advance assessment, no matter how thorough one's knowledge of oneself or another, for, except in general terms and over-all predictions, one's resources are only known in the situation itself. This is because one's resources, one's potentialities, do not simply inhere in one as a part of one's make-up, but are called out of one in response to what meets and demands one in this hour.

"What is possible in a certain hour and what is impossible cannot be adequately ascertained by any foreknowledge. . . . One must start at any given time from the nature of the situation in so far as it is at all recognizable. But one does not learn the measure and limit of what is attainable in a desired direction otherwise than through going in this direction. The forces of the soul allow themselves to be measured only through one's using them. . . . One cannot strive for immediacy, but one can hold oneself free and open for it. One cannot produce genuine dialogue, but one can be at its disposal."[3]

Philosophical Anthropology

Buber's philosophy of dialogue has found its most thoroughgoing philosophical base in the philosophical an-

thropology which Buber has developed in his later years. Philosophical anthropology is concerned with the uniqueness of man, what makes man a problem to himself. Man is an animal, yet man differs from all other animals, and he cannot understand himself as man apart from this difference. No approach to the problem of human society that is content to carry over an organic biological analogy from the life of animals without dealing with the specific problematic of man can claim our serious attention as a contribution to the understanding of man. The suggestiveness of such organic analogies is deceptive; their appeal is often based on the desire to escape from the problem of man, the desire to reduce man to the safer general categories that biological science has discovered for all animals, the desire of the scientist to escape responsibility, in fact, for his participation even as knower in what he is seeking to know—human existence.

In "What Is Man?" Buber establishes the focus of the problem of man in the "interhuman," the "sphere of the between." Man, essentially, is neither a gorilla nor a termitary, neither a self-sufficient, primarily isolated individual, such as Freud saw man, nor an organic collectivity. The fundamental fact of human existence is man with man, the genuine dialogue between man and man. The psychological, the psychic stream of happenings within each man, is only the accompaniment of the dialogical. It is not itself the reality and goal of human existence. "All real living is meeting." Individuation is not the goal, only the indispensable way to the goal. This point is absolutely central to Buber's thought and it cannot be emphasized too strongly. Many psychotherapists and psychologists, such as Erich Fromm and Carl Rogers, who today recognize the essential importance of mutual relations between men still see these relations largely as the function of the individual's becoming and the means to that end. As long as dialogue is entered *merely* as a means to the end of health, maturity, integration, self-expression, creativity, "peace of mind," "positive thinking," and richness of experience, it will not even produce those things, for it will no longer be true dialogue and will afford no real meeting with the other.

Distance and Relation

In 1957, Martin Buber was brought to America by The Washington School of Psychiatry to deliver the Fourth William Alanson White Memorial Lectures. These lectures—"Distance and Relation," "Elements of the Interhuman," and "Guilt and Guilt-Feelings"—provide us with the latest and most important stage of Buber's philosophical anthropology. Through contrasting man with the rest of nature, Buber derives a twofold principle of human life consisting of two basic movements: "the primal setting at a distance" and "entering into relation." The first movement is the presupposition for the second, for we can only enter into relation with being that has been set at a distance from us and, thereby, become an independent opposite. Only man can perform this act of setting at a distance because only man has a "world" (*Welt*)—an unbroken continuum which includes not only all that he and other men know and experience, but all that is knowable now and in the future—while an animal only has an environment or realm (*Unwelt*). "Only the view of what is over against me in the world in its full presence, with which I have set myself, present in my whole person,

in relation—only this view gives me the world truly as whole and one."

Distance given, man is able to enter into relation with other beings ("I-Thou") or to enlarge, develop, accentuate, and shape the distance itself, turning what is over against him into his object ("I-It"). An animal cannot see its companions apart from their common life, nor ascribe to the enemy any existence beyond his hostility. Man sets man at a distance and makes him independent. He is, therefore, able to enter into relation, in his own individual status, with those like himself.

Confirmation and "Imagining the Real"

"The basis of man's life with man is . . . the wish of every man be to confirmed as what he is, even as what he can become, by men; and the innate capacity in man to confirm his fellow men in this way. . . . Actual humanity exists only where this capacity unfolds."[4]

This mutual confirmation of men is most fully realized in what Buber calls "making present," an event which happens partially wherever men come together, but in its essential structure only rarely. Making the other present means to "imagine the real," to imagine quite concretely what another man is wishing, feeling, perceiving, and thinking. The particular pain I inflict on another surges up in myself until, paradoxically, we are embraced in a common situation. It is through this making present that we grasp another as a self, an event which is only complete when he knows himself made present by me. This knowledge induces the process of his inmost self-becoming, "for the inmost growth of the self is not accomplished, as people like to suppose today, in man's relation to himself." An animal does not need confirmation because it is unquestionably what it is. A man needs confirmation because he exists as a self, at once separate and in relation, with unique potentialities that can only be realized if he is confirmed in his uniqueness. "Sent forth from the natural domain of species into the hazard of the solitary category, . . . secretly and bashfully man watches for a Yes which allows him to be and which can come to him only from one human person to another."[5]

Buber describes "imagining the real" as a "bold swinging" into the life of "the particular real person who confronts me, whom I can attempt to make present to myself just in this way, and not otherwise, in his wholeness, unity, and uniqueness."[6] "Imagining the real" is crucial for genuine ethical responsibility, in which one's response is not to subjective interest or to an objective moral code, but to the person one meets. It is also essential for friendship and love, in which each member of the relationship is made present by the other in his concrete wholeness and uniqueness. But imagining the real is also essential for all the helping relationships—pastor and congregant, teacher and student, therapist and patient. If we overlook the real "otherness" of the other person, we shall not be able to help him, for we shall see him in our own image or in terms of our ready-made categories and not as he really is in his concrete uniqueness. But if we allow him to be different and still accept and confirm him, then we shall have helped him realize himself as he could not without us. No amount of knowledge on the part of the teacher and no amount of scientific technique on the part of the doctor and the psychotherapist can make up for the failure to experience the relationship from the side of the other as well as from our own.

"Healing Through Meeting" and One-sided "Inclusion"

In friendship and love, "inclusion," or experiencing the other side, is mutual. In the helping relationships, however, it is necessarily one-sided. The patient cannot equally well experience the relationship from the side of the therapist or the pupil from the side of the teacher without destroying or fundamentally altering the relationship. This does not mean that the therapist, for example, is reduced to treating his patient as an object, an It. The one-sided inclusion of therapy is still an "I-Thou" relation founded on mutuality, trust, and partnership in a common situation, and it is only in this relation that real therapy can take place. If "all real living is meeting," all true healing also takes place through meeting. If the psychotherapist is satisfied to "analyze" the patient, "i.e. to bring to light unknown factors from his microcosm, and to set to some conscious work in life the energies which have been transformed by such an emergence, then he may be successful in some repair work. At best he may help a soul which is diffused and poor in structure to collect and order itself to some extent. But the real matter, the regeneration of an atrophied personal center, will not be achieved. This can only be done by one who grasps the buried latent unity of the suffering soul with the great glance of the doctor: and this can only be attained in the person-to-person attitude of a partner, not by the consideration and examination of an object."[7] But a common situation does not mean one which each enters from the same or even a similar position. In psychotherapy the difference in position is not only that of personal stance, but of role and function, a difference determined by the very difference of purpose which led each to enter the relationship. If the goal is a common one—the healing of the patient—the relationship to that goal differs radically as between therapist and patient, and the healing that takes place depends as much upon the recognition of that difference as upon the mutuality of meeting and trust.

> "In order that he may coherently further the liberation and actualization of that unity in a new accord of the person with the world, the psychotherapist, like the educator, must stand again and again not merely at his own pole in the bipolar relation, but also with the strength of present realization at the other pole, and experience the effect of his own action . . . the specific "healing" relation would come to an end the moment the patient thought of, and succeeded in practising "inclusion" and experiencing the event from the doctor's pole as well. Healing, like educating, is only possible to the one who lives over against the other, and yet is detached."[8]

The "I-Thou" relation must always be understood in terms of the quite concrete situation and life-reality of those participating in it. Here the full reality of the concrete situation includes the fact that one is a sick man who has come to the therapist for help, the other a therapist who is ready to enter a relationship in order to help. This excludes neither Erich Fromm's conviction that the therapist at the same time heals himself in some measure through his own response to the patient, nor Carl Rogers' feeling of the equal worth and value of the client (which leads Rogers, mistakenly in my opinion, to stress the full mutuality of the client-therapist relationship), nor Trigant Burrow's and Hans Syz's emphasis on an "inclusive therapy" in which, particularly in group therapy, the therapist aids the patients by allowing them to see some of the social

and personal distortions in himself.[9] But it does preclude accepting the therapist's *feeling* of mutuality as equivalent to the actual existence of full mutuality in the situation *between* therapist and patient. The "scientific" impersonalism that characterized the orthodox conception of the psychoanalyst is rightly rejected by many present-day therapists. But this should not lead us to a sentimental blurring of the essential distinction between therapy and other, less structured types of "I-Thou" relations. In the latter, as Buber puts it, there are "no normative limitations of mutuality," but in the former the very nature of the relationship makes full mutuality impossible.

The Essential We

The relation between man and man takes place not only in the "I-Thou" relation of direct meeting, but also in the "We" of community. As the "primitive Thou" precedes the consciousness of individual separateness, whereas the "essential Thou" follows and grows out of this consciousness, so the "primitive We" precedes true individuality and independence, whereas the "essential We" only comes about when independent people have come together in essential relation and directness. The essential We includes the Thou potentially, for "only men who are capable of truly saying *Thou* to one another can truly say *We* with one another." This We is not of secondary or merely instrumental importance; it is basic to existence, and as such it is itself a prime source of value. "One should follow the common," Buber quotes Heracleitus, i.e., join with others in building a common world of speech and a common order of being.

"Man has always had his experiences as I, his experiences with others and with himself; but it is as We, ever again as We, that he has constructed and developed a world out of his experiences."

Thus amid the changes of world image, "the human cosmos is preserved, guarded by its moulder, the human speech-with-meaning, the common logos."[10]

The importance for group psychotherapy of Buber's concept of the common world as built by the common speech-with-meaning can hardly be overestimated. Speech, from this point of view, is no mere function or tool, but is itself of the stuff of reality, able to create or destroy it. "Man has always thought his thoughts as I, . . . but as We he has ever raised them into being itself, in just that mode of existence that I call 'the between.'" Speech may be falsehood and conventionality, but it is also the great pledge of truth. Whether he takes refuge in individualism or collectivism, the man who flees answering for the genuineness of his existence is marked by the fact that he can no longer really listen to the voice of another. The other is now only his object that he observes. But true dialogue, as Franz Rosenzweig pointed out, means that the other has not only ears but a mouth. He can say something that will surprise one, something new, unique, and unrepeatable for which the only adequate reply is the spontaneous response of the whole being and nothing that can be prepared beforehand. Only if real listening as well as real talking takes place will the full possibility of healing be present in group psychotherapy, for only thus, and not through any mere *feeling* of group unity, will the full potentiality of the group as a group be realized. "He who existentially knows no Thou will never succeed in knowing a We."[11] One *should* follow the common, and that means that lived

speech, "speech-with-meaning" is itself a value. Values are not just the content, the building-blocks of speech. They exist, in the realest sense, in the "between," in the dialogue between man and man. From this standpoint one might question the ultimate validity of a distinction between "values" and "views" which makes the former an objective content, the latter a subjective attitude, and leaves no room for valuing as a dialogical human reality.[12]

It is not only the fate of groups that depends upon the common "speech-with-meaning." If man does not recover the genuineness of existence as We, he may cease to exist at all.

"In our age, in which the true meaning of every word is encompassed by delusion and falsehood and the original intention of the human glance is stifled by tenacious mistrust, it is of decisive important to find again the genuineness of speech and existence as We. . . . Man will not persist in existence if he does not learn anew to persist in it as a genuine We."[13]

Guilt and Guilt-Feelings

The centrality of man's existence as We is basic to Buber's distinction between "groundless" neurotic guilt—a subjective feeling within a person, usually unconscious and repressed—and "existential guilt"—an ontic, interhuman reality in which the person dwells in the truest sense of the term. The analyst must see the illness of the patient as an illness of his relations with the world. "A soul is never sick alone," writes Buber, "but always through a betweenness, a situation between it and another existing being." True guilt does not reside in the human person but in his failure to respond to the legitimate claim and address of the world. Similarly, the repression of guilt and the neuroses which result from this repression are not merely psychological phenomena but events between men.[14] Existential guilt is "guilt that a person has taken on himself as a person and in a personal situation," an objective dialogical guilt that transcends the realm of inner feelings and of the self's relation to itself. Existential guilt is the corollary of the answerability and responsibility of the self in the concrete dialogical situation. It is failure to respond and, by the same token, failure to authenticate one's existence. "Existential guilt occurs when someone injures an order of the human world whose foundations he knows and recognizes as those of his own existence and of all common human existence."[15] This "order of the human world" is not an objective absolute existing apart from man: it is the interhuman itself, the genuine We, the common logos and cosmos. What it means to injure this common order is known to every man who has experienced real guilt, but also to every group therapist who has had to discover the direction his group must take for real therapy, and in so doing, like Alexander Wolf, distinguish between constructive and destructive group trends and constellations.[16] The therapist may lead the man who suffers from existential guilt to the place where he himself can walk the road of illuminating that guilt, persevering in his identification of himself as the person who took on that guilt, and, in so far as his situation makes possible, restoring "the order of being injured by him through the relation of an active devotion to the world."[17] "In a decisive hour, together with the patient entrusted to him and trusting in him," the therapist "has left the closed room of psychological treatment in which the analyst rules by means of his systematic and methodological superiority and has stepped

forth with him into the air of the world where self is exposed to self. There, in the closed room where one probed and treated the isolated psyche according to the inclination of the self-encapsulated patient, the patient was referred to ever-deeper levels of his inwardness as to his proper world; here outside, in the immediacy of one human standing over against another, the encapsulation must and can be broken through, and a transformed, healed relationship must and can be opened to the person who is sick in his relations to otherness—to the world of the other which he cannot remove into his soul."[18]

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8. Ibid.: 133.
9. Erich Fromm's statement is from a personal conversation I had with him in which he indicated his full acceptance of the principle of "healing through meeting." That of Rogers is from a dialogue I moderated between him and Martin Buber at the University of Michigan in March, 1957, the transcript of which has been privately circulated by Dr. Rogers but not printed. In this dialogue the difference between the two men becomes apparent, not only in this point, but in Rogers' belief that man is basically good, Buber's that he is polar, with his strongest capability of good being coupled with his strongest potentiality of evil; Rogers' emphasis on unqualified acceptance as opposed to Buber's emphasis on a confirmation which, while it accepts the other as a person, may also wrestle with him against himself; Rogers' emphasis on subjective becoming and dialogue as a means to that becoming, Buber's emphasis on dialogue with the becoming of the self only an aspect of dialogue rather than its goal. Buber could not accept Rogers' statement that he treats neurotics, schizophrenics, and paranoiacs the same and that he has full mutality with them as a description of the situation but only of Rogers' feeling about the situation. For a description of the approach of Burrows and Syz, cf. Hans Syz, "An Experiment in Inclusive Psychotherapy," *Experimental Psychopathology*, 1957, 129-169.
10. Buber, Martin: "What Is Common to All," trans. by Maurice S. Friedman, The Review of Metaphysics, Vol. XI, No. 3 (March, 1958), 377.
11. Ibid.: 378.
12. This distinction between objective "values" and subjective "views" was presented by Richard W. Boyd in his paper "Research on Process and Basic Values in Group Psychotherapy" read at the same panel as the present paper.
13. Cf. 10, above: 378.
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EXISTENTIAL ANALYTIC PSYCHOTHERAPY

WILSON VAN DUSEN

EXISTENTIAL ANALYSIS is an example of a theoretical advancement which has far outstripped the development of actual techniques adapted to the new theory. There is no accepted technique of psychotherapy in existential analysis.[1] The technique varies with the analyst. What remains the same is the general program as to how the patient should be regarded and understood. All such analysts will begin with an attempt to understand the phenomenological world of the other person. Beyond that there are wide differences in practice. In part these differences are fruitful since they represent a continued exploration unhampered by a dogma of technique.

Two points will be made here. The first is that there is such an organic unity between the phenomenological approach and existential theory that the theory can and will be derived here from the basic phenomenological frame of reference. The second point is that there is a psychotherapeutic approach which most closely fits the theory. In fact a close adherence to the theory demands a particular approach. The approach has been called gestalt therapy, and considerable credit for it is due to Dr. Frederick S. Perls.[2, 3] So, in addition to rederiving existential analytic theory from its phenomenological foundations, we will show a psychotherapeutic approach which fits this theory.

The door into existential analysis is through phenomenology and in this case the structure of the door implies much of the house. In the phenomenological approach to another person, one attempts to understand his mode of being-in-the-world. There are a number of immediate and important implications. One is not coming to his world with objective yardsticks or categories. One cannot translate his world into oral, anal, genital, id, ego or superego terms unless the patient spontaneously sees these as real characteristics of his world. There is no objective, outside-of-him system into which one can fit his world. One must be ready to discover worlds radically different from one's own. The patient's world may be a hole-like one out of which one crawls laboriously to look momentarily at daylight. His may be the seething restless world of the hipster,[4] where one swings from orgasm to orgasm in an attempt to break out of all boundaries. In every classificatory system our worlds differ relatively little, but in a phenomenological approach one encounters strange and radically different worlds. In therapy my own criterion as to whether I have understood the world of the other is whether or not he can recognize his world in my description.

The other day I examined a chronic schizophrenic patient of a colleague in an effort to get him more information

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Wilson Van Dusen, Ph.D., University of Ottawa, 1952, is chief clinical psychologist at Mendocino State Hospital, Talmadge, California, and managing editor of the journal, *Existential Inquiries*.

about the patient. He told the patient I felt he was psychotic and the patient became angry and launched into a disturbed denial. Actually, I agree with the patient. He is not psychotic (the external-objective classification of him). Rather, he lived on the surface in his eyes and his tongue because his brain and heart were paralyzed. Of course, the patient is technically psychotic, but in a phenomenological approach I don't wish to be technical. I told the patient that I really saw him as living in his eyes with a paralyzed brain, and he accepted this. Someone understood him. He felt my colleague so misunderstood him as to be psychotic himself.

This is the effect of the phenomenological approach. Insofar as one can describe the world of the other person as he finds it, the other person feels understood. Then one can work with him in full communication and interchange. From the paralyzed brain and heart we go to other aspects of his world. He feels safe. He is understood. Any sort of judgment or technical approach to his world leaves him with the justified feeling that the therapist is bending him to the therapist's own ends. One discovers the being-in-the-world of the other, with even the terms and all the subtle qualities of the world of the other. This does not imply I am in his world. At the end of the hour he goes back to his hospital ward or his home and I return to my other professional duties. He knows I do. He knows mine is a different world. But as he leaves the door he feels someone is beginning to understand how he feels. I don't need to pretend to be in his world. When he says he is being poisoned I can quite seriously accept that he feels poisoned and even explore the qualities and circumstances of this poisoning without pretending I feel that material poison is being slipped into his food. Usually he doesn't literally mean poison *qua* poison. Even if he does, our exploring his poisoned world should open up other and more psychic aspects of poisoning.

So far we have said that the door into existential analysis is through an attempt to understand (not judge or value) the being-in-the-world of the other. This understanding is in his terms, with his qualities. It is the opposite of any sort of objective or technical approach to him, such as a diagnosis implies, for instance. He feels understood and not apprehended and bent by the other person. In this one need not pretend to have a world exactly like his. One remains an individual with a different world. He doesn't feel he is with an expert with mysterious powers. He is with another person who is attempting laboriously and slowly to understand him. Nor is he with the lover who cries when he cries. The transference is less than in classical analysis. As one meets and learns to describe the patient as he is here, one is also uncovering transference reactions. They too are described as part of his present being-in-the-world. They are discovered as they form and described so that they won't have a hidden effect on the relationship. If you wish, one could say there is a continuous analysis of transference. This phenomenological entering into the being-in-the-world of the other is the foundation of existential analysis. It is so fundamental that the therapist who learns how to do this alone is very likely to discover spontaneously for himself all the other aspects of existential analysis.

There are a number of collateral discoveries once one has entered the phenomenological door. Most of science is an attempt to find static law. One finds the world of the other is fluid and changing. The schizophrenic living in

his eyes will be found to have a far richer and complex world than appears at first sight. Also it changes as we come to understand it. In one schizophrenic we are exploring a gesture as simple as rubbing his nose. It was at first a filling up of a hole of nothingness.[5] As we looked further it took on many and varied meanings. Not only is the therapist learning, but the patient is recalling in a gesture aspects of himself he had lost. We explore his style of movement, the changing emotional qualities in his voice and his experiences here. Whereas he may have appeared simple to himself, he grows more complex, varied, and subtle in this exploration. A simple sympton takes on layers of emotional and interpersonal meaning. As we explore, his awareness expands. He is not the same person from moment to moment. Nothing has been done to him. He hasn't been interpreted. He has simply participated in a discovery of himself here.

Another implication is that one will not want to discard any part of his being-in-the-world. One will not look exclusively at the outer world as he sees it, or at the internal. Both are his world. He may live more in one or another sphere (the introvert-extrovert dichotomy). If the solidity and resistance of material things engages him then we will look at this. If a fantasy plagues him, then it is an important part of his world.

Dreams can be used as an important part of this discovery. Boss[6] makes the important point that dreams are not, strictly speaking, symbolic. They speak in a purely existential language. They tell what is currently critical in one's life by describing it in terms of dramatic events. Dr. Perls goes after the meaning of dreams by having the patient play-act all aspects of the dream until the patient is caught up in the events and thereby finds their meaning.

Also, one will not grasp the patient solely by his words (a tendency in many overly logical therapists). Features of his world are his bodily sensations, his use of his musculature, his gestures, his choice and use of clothes, and even the inflections of voice underlying the words. Such a small matter as where he puts his gaze is quite important. Does he communicate eye-to-eye with the therapist or is he talking to a potted plant in the corner? No part of his world is so small as to be meaningless. This approach to patients implies a much richer and more subtle understanding than the simple grabbing another by his words. I would hope to be able to fully understand another person without having heard a single word of his. It would please me immensely to be able to imitate his movements and the sound of his voice, for then I have grasped some of his uniqueness.

In the exploration of the world of another person one tends to center on the critical. In the past, experimental psychologists centered on unimportant aspects of the worlds of others. Look, for instance, on the vast number of studies of the two-point sensory threshold and similar works. They did this to grasp what could be translated into the modes of exact science. Because the psychotherapist is not attempting to catch what is measurable by science, he can afford to look at the critical. There is a most simple reason why the existential analyst centers on the critical. The patient insists on it. The patient's life and destiny are at stake. He cannot help but present the critical, even though what he presents may look very peripheral to the therapist. The term existential has come to be nearly equivalent to the term critical. How does one find the critical? By exploring all the

aspects of the being-in-the-world of the other.

The space-time aspects of the world of the other person are found to be important. In classical Freudian psychoanalysis, the analyst shifts the patient back into an exploration of the patient's history. In exploring the being-in-the-world of the other, one explores the world here, now. Only insofar as past or future are tangled in the world here-now do these become of consequence. After all, his world is here-now. It's not back in toilet training in childhood or forward in after-life. He sits here before me and demonstrates his world. The centering in the here-now is a modern tendency coming into most therapies. Practically speaking, it causes an intensification and speeding up of therapy. There isn't the long escape into what mamma, papa, or sister did. "We are here. What are you doing now?" One need not wander for years examining aspects of the person projected in remote historical events. The person is here. We can study what he does here. In the hereness he shows how he chooses space, time, and the qualities of his world. One patient occasionally rubbed his hand across the bridge of his nose. It was perhaps two weeks before we began to understand this. The meaning was something like this. "I become anxious under your close regard (or anyone else's). In the anxiety, time and space suddenly develop a frightening hole. In the hole is nothing. I can't even remember. Nothingness. By touching my nose I am physically active and fill up the hole. Also I touch physical reality (my body) and come back to reality that way. Incidentally, my hand covers my eyes for a moment and your (analyst's) gaze is shut off for a moment." Here we began to discover his problem in a palpable way. It is with us here. It is not in the historical past. It is so palpable we can study it together now.

With the basic phenomenological approach I believe many others will discover that to some extent all study of past or future is a subtle abrogation of present responsibility. One cannot exclusively steer the patient into the present, either. If the past or future intrudes into the session it says something about how the patient is present. In the existential-analytic approach one doesn't steer the patient into past, present, or future. One discovers where the patient is now in his present being-in-the-world. It is a simple discovery in this approach that all psychopathology involves some degree of escape from the here and now into the spatially or temporally there, into otherness. The well-integrated person looks at the therapist, eye-to-eye, with security and composure, and chooses his being-in-the-world now. He is content to be here.

In this approach one will undo projections as fast as they form. The patient may ask, with some feeling, "Do you think therapy should go on indefinitely?" The patient is bothered and is projecting responsibility onto the analyst. The analyst can help bring the projection back to the patient by simply asking: "Would you make that into a statement?" The patient says, "You feel therapy should be interminable." There is a little more emotion in the voice and actions. Can the patient say it again clearer and more forcefully? "You feel therapy should go on forever!" After a moment the analyst can ask how the patient feels now. What was projected into the other is then discovered as arising from one's own emotions. Usually the patient reacts after such an exchange as though he had been restored to power. The projection was not interpreted as a defect in the patient. The affect underlying it was re-

covered and the patient was restored to power.

There is no unconscious in this approach.[7] Nothing is totally outside the realm of his present being-in-the-world when that world is examined in considerable detail and with considerable respect. One finds himself dealing with varying degrees of awareness from what is easily verbalized to not quite understood gestures to vague feelings that are not at first verbalized. Nothing is totally outside of his present being here (hence the term "dasein-being here-analysis"). There are a great many ways of exploring the present. While the patient talks, something of an emotion may show in the eyes, or voice, or a gesture appears. When the emotion is strong enough to grip the person, then a simple noting of its presence by the analyst may help bring it to the fore. With a little help its expression becomes clearer. Something has been discovered in the testing ground of the present relationship. He finds and determines himself, rather than finds himself interpreted by another person. Well-handled, one can tell from moment to moment whether gains are being made because the pathology and the choices around it are here.

In this I am dealing with findings from the phenomenological approach which others may not have experienced yet. I am so secure in these findings, though, that I would be inclined to say that anyone who has learned to understand the being-in-the-world of others and is involved in their care in psychotherapy will of himself enter into existential analysis. At this point I would like to clarify what differentiates between the phenomenological entrance and the inside of the house of existential analysis. In a few words, the entrance is phenomenological, the inside of the house is ontological, the essential nature of man.[8] This was touched upon when we examined the critical and found it in the here and now. In the other (there, in time and space) it is hidden. One can center on the ontological, the critical, and the here and now by exploring the patient's choosing.

All the productions of the patient (words, actions, dreams etc.) are, so to speak, puppets. By examining his choosing here and now with me, I deal directly with the puppeteer. This is the existential engagement. He is caught. All avenues of escape are sealed. As he grows in awareness of the size and qualities of his world, his area of choice expands. In the beginning of therapy it appears he had no choice. He was caught as an actor in a repetitive, unpleasant drama. As awareness of his world expands he comes to deal with the playwriter—his forgotten choices. The drama changes. It appears more and more that he writes the drama. Therapy ends without any massive transference, because the therapist was no all-wise magician. He only permitted the patient to discover and choose himself.

In case it is not clear that this is relatively different from most other forms of psychotherapy, the difference will be underlined. Here there is no need to explore, or even to know, a patient's history. One could fully explore what is wrong here and what is chosen here without a history. In this approach there is no unconscious. His world is here. There are varying degrees of awareness in that world. There is no resistance or defense. This may be difficult to see, but both resistance and defense imply one is outside the world of the other and makes an outsider's judgment of their world. There is no denial. To say the patient is denying is to say that the analyst has a conception of the world of the patient that

does not match with the patient's world. The patient doesn't deny. He states what he knows of himself at the moment. In this form of therapy both transferences should never become intense and burdensome. If you want, it is because this therapy is almost a constant analysis of transference, though even the term "analysis" is out of place here. One doesn't come to analyze (take apart) the world of the other. One comes to understand it. These few examples of differences from ordinary psychotherapy should suggest that this form of existential analytic therapy is relatively new. It has historical roots in the work of Adler, Rank, gestalt therapy, and the work of Freud, but in itself it is a major shift in what is seen as psychotherapy.

Summary

Existential analysis is not yet identified with a particular therapeutic approach. By beginning with a phenomenological foundation one can rederive the structure of existential analysis, and by so doing one discovers a technique that is particularly close to the theory of existential analysis. From phenomenology one learns to enter the present being-in-the-world of the patient without overlooking any of the qualities of that world. By centering in the present world one discovers the critical and the role of the patient's choosing. By this the patient feels understood and not interpreted, and discovers that he changes as the horizon of his present experiences expands. Starting from a phenomenological foundation one rediscovers existential analysis and discovers that this analysis is a significant departure from classical therapies in several respects.

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THE MOMENT IN PSYCHOTHERAPY

ARTHUR BURTON

IN THE PSYCHOTHERAPY of schizophrenic patients the distinctions between patient and psychotherapist are bolder in relief and more critical than they are with neurotics. These distinctions early led to the widely accepted belief that a transference is impossible with a schizophrenic patient. To do psychotherapy successfully with such patients, it is necessary for us to examine these distinctions to see how the gap might best be bridged. In the past we have tended to avoid such examination by using hypothetical diagnostic constructs in a Procrustean way. This essay is concerned with only one facet of the problem; but one which basically cuts across the existential relationship of patient and psychotherapist. By this I mean *time,* or temporality.

Time is a subtle, enveloping concept that serves culture well and has been accepted by the layman as something immutable as the air we breathe or the rays of the sun which shine upon us. It may, in fact, be the best single mark of acculturation, and certainly occupies a central position in the dilemma of modern man, i.e., the human condition. To be *time-bound* is to be culture-bound by definition. One has only to experience the timelessness of a country such as Spain to perceive the shackles we all wear. More recently, psychology and psychiatry have been concerned with the length of psychotherapy and have sought ways of reducing it. Thus, we have short-term therapy, group therapy, family therapy, multiple therapy, and even therapy which takes place in a single hour—all designed to speed things up. Not much thought, however, has been given to the meaning of *time* within the therapeutic setting itself—to its dynamic meaning to the individual participants. We are more and more forced to the possibility that schizophrenia may be an existential disorder[1] and, as such, may be one product of culture—a product, however, deemed pathological. Can it be that the experience of *time* is related to schizophrenia, that a new perspective about temporality may assist us in closing the gap between patient and therapist?

Time has no meaning of its own and no content. It is a universal binder which provides a coherency to processes having integrity in their own right and a certain hegemony. We have reified *time* and by so doing surrendered a qualia for a quantum.[2] Shlien poses the problem in this way:

"Time is an abstract concept having no concrete or active properties of its own, and therefore practically means nothing. We all realize that time is measured only by change, but life in a clock culture wrongly teaches us to think otherwise. We

Arthur Burton, Ph.D., University of California, 1940; chief clinical psychologist, Agnews State Hospital. He is the contributing editor, with R. E. Harris, of *Case Histories in Clinical and Abnormal Psychology* and *Clinical Studies of Personality*, and contributing editor of *Case Studies in Counseling and Psychotherapy* and the *Psychotherapy of the Psychoses*. He is a member of the American Academy of Psychotherapy and the American Psychological Association.

learn to think in terms of a '9 to 5' work day, not of work. The legal code tells us that time 'is of the essence'. It is not. The true essence is energy. We are told, in the psychological realm, that 'time heals'. It does not. All the time in the world cannot heal anything. There is some healing process, which we barely know, taking place in time. Merely 'putting in time' signifies nothing, leads to nothing."[3]

There is thus a *time* mythology to which all of us cling tenaciously. This myth involves the causality and productivity of *time,* its infinite (human) nature, and its regenerative, reliving qualities. Subscription to the myth makes us believe that one moment is as good as the next, one day like any other, this week like last week, etc. A temporal sameness is produced which becomes the characteristic of man's humdrum existence. Often he waits patiently for *time* to change something in his life only to come desperately to realize his finiteness. Then he may have feelings that if he cannot live forever, he would rather not live at all. *Time* is a constant, he believes, and relativity a particle on a great Absolute.

The psychotherapist, of course, is not immune to the myth, and *time* is a very troublesome thing for him. He looks forward to a certain elapsed *time* in his training and training analysis. In his practice he is constantly arranging and disarranging it, and the loss of his appointment book is apt to produce panic. His income and status tend to be measured by it and, in addition, he is expected to have a spouse, raise children, be a member of the community, and participate in similar ventures in the limited temporal span allotted him. The involvement of the psychotherapist with *time* is even greater, it seems, than other members of culture. This is no happenstance, for it is precisely the problem of *time*—finiteness and infinity—that the schizophrenic patient brings to him, and the psychotherapist is himself involved with the problem of his own existence.[4] But while these problems may be recognized as such by the psychotherapist, their contribution to the treatment of the schizophrenic patient is frequently overlooked.

If two people meet for therapeutic purposes and the value-system of one is *time-bound* and of the other is *timeless,* what can be expected from the encounter? The result, on both sides, is a feeling of frustration, of not being understood. *Time*—as space—is a fundament of our being-in-the-world; if there is no agreement on the basic parameter upon which the human drama is played, then it is easy to see that the schizophrenic patient will be loathe to give up his existential conflict which involves the Absurd.[5] For the schizophrenic patient, the 50-minute hour or the twice-a-week visit is meaningless. He does not understand the artificialities which surround these things—and, of course, was it not like his mother who had to leave him for the PTA meeting so that his sister might develop properly! It is just because *time* has lost its meaning that we have the patient. All is now archaic, paleologic, and symbolic—for the primitive, *time* is not of the essence, as preliterate art testifies. Something very dear to all of us is our chronological age—man or woman—and we are very cognizant of the physical alterations which indicate the passing of *time.* But ask a schizophrenic patient her age and she will tell you one time that she is 20, and at another that she is 50. The question is just not relevant to the schizophrenic situation.

We have then, if you will, two parallel *time-systems*—in the patient and the psychotherapist—which have to be reconciled. This reconciliation cannot be

taken lightly, for the experience is that most psychotherapists cannot do it—they are unsuccessful in treating schizophrenic patients—and that at any rate it comes only with the greatest of difficulty. In the face of humanity the analyst is not privileged.[6] He is a being encountering another being and who is to say which *time* shall apply? Actually, the human condition today has fostered a revolt against *time,* which is manifested in part by the Beat Generation, and in part by all human beings.

There are a number of problems this situation poses, but let us consider just one for the moment.

We say that the schizophrenic patient develops a thinking disorder that is unique and lacks communicative properties. We can, for example, demonstrate neologisms on a vocabulary test, which seem truly deviated from what we know as logical thinking. We then use such deviations as a diagnostic hallmark of the schizophrenic patient. Consider for the moment a statement made by a schizophrenic patient after hours of apparently fruitless analysis: "Let us try one another."[7] This remark has the cryptic, symbolic, and paleologic import of all schizophrenic thinking. What it does is to communicate something of the greatest meaning in a shorthand and alienated way; by itself it is unique and idiosyncratic. The patient is actually saying to her psychotherapist: "I find you worthy as a human being and I entrust my being to you. While I am content to leave this Absurd world behind, you have revived my faith in it and I will encounter you in all my humanity." Another schizophrenic patient, hospitalized in a state hospital for a long period, says, "I am not worthy of being a resident in this hospital." Yet she knows that she has come to the end of the road, having failed in several years of treatment in a university hospital, and that she may be hospitalized for the remainder of her life. What does she mean by this? Is it that, in her eyes, she has become so degraded that she is not even worthy of the company of her fellow patients? Or of her therapist? Does it not tell us of the state of her being-in-the-world in a unique and significant way? What of the patient who says, "My mother is holding my feelings for me." Is the message not pregnant?

There is no such thing as schizophrenic thinking. There is only thinking adapted in its logical and communicative properties to one's world in its broad ramifications. *Time* not being of intrinsic value, the schizophrenic patient cannot wait for the logical and cultural aspects of thought. He cuts across them by abridgement and symbolization.

Time involves the problem of the *moment* and of infinity. In this paper we are only directly involved with the former. In every-day life the *moment* is considered to be without substance, of a transitory nature, and of no great consequence. Every *moment* is like all other *moments* and transitivity applies. When we ask someone to wait a *moment,* we actually mean several *moments;* the significance of that special *moment* is thus lost. It is reasonable to behave in this way if one believes that there is an infinity of future *moments,* or that the past governs by itself without regard to present. Indeed, individual historicity received such tremendous impetus from psychoanalysis that we became a somewhat backward-looking culture. This is a distortion, of course, but certainly the present has been lost somewhere in limbo. Yet, despite the layman's discreditation of the *moment,* he knows that he has experienced a number of critical *moments* which have been governing in

his fate. These may have occurred with or without his conscious participation, but he is aware that they were of the highest order of significance. His incredulousness may actually be a defense against such *moments* as birth, saying "I do" in marriage, conception, career commitment, etc., which bind him "forever and ever." We are all familiar with those *moments* in which fate and destiny side. They are probably best exemplified by military campaigns in which tides of battle hang on *moments* where human lives, territories, and even future modes of existence hinge.

We like to assume that *time* has certain unique properties which serve our needs. If it were simply a matter of sidereal or mathematical time, the problem would be simple. We would then have physical units of *time* susceptible of definition by relativity. We anchor the *time,* so to speak, to some higher order of regularity, and even though we do not understand the nature of the regularity, it is above the *time* which is inner to man. In this way, we then proceed to differentiate and segment our lives.

Unfortunately, man does not participate in this physical process with his being. He is caught up in it—a prisoner, as it were—and despairs of it. His inner or psychological time is not of this order, and it is his inner nature which is attempting reconciliation. Several experimentts of the writer have demonstrated that a *time* interval varies whether one feels bored or motivated, engaged or disengaged, and with the process which is taking place in *time.*[8] Thus there are fast clocks and slow clocks, and some clocks which have stopped altogether. Force the average man to depend on *psychic-time* and the response is anxiety. If the deprivation is sufficiently long and intense, psychotic-like behavior may obtain.

Thus, a *moment* is not like all other *moments.* It is a *moment-for-itself* and must be understood this way. Of course, *moments* elide into themselves and become sequent moments or processes. To attempt a strict definition here would lead us into a morass. For our purpose, the *moment* is an existential reference to *being* at a place or location of significance. It is the medium through which life and existence is translated; it has no intrinsic value in its own right. Without some such formulation, time must become static and meaningless.

Now it so happens that with schizophrenics the *moment* is of the greatest significance, in a sense the secret of his existence. It is because *psychic-time* stands still while all about him moves that he is in despair. The future is unreachable because there is no present and so he becomes a *to-be-as-before.* His negation is the negation of the principal hallmark of culture: *time.* He refuses to live by *time* as we know it. There is no greater rebellion than this in the eyes of culture. Nations in this condition we consider backward and primitive. With individuals, we are apt to call them sick. With the perversion of *time* comes the alteration of space. To occupy the minimum of *time,* the schizophrenic employs the smallest quantum of space: he does not move. The temporal-spatial disorder thus fixes him once and for all on a sickness continuum to which we give a distinctive cognomen.

Persons in this state are excruciatingly aware of the significance of the *moment.* They seek and evade the critical *moment*—and *all* become critical, and *none* are critical. It is a kind of watchful, social anarchy in which *moments* affirm and disaffirm in an excruciating way. Thus, the therapeutic encounter

with the psychotherapist becomes a vehicle for the *moment.*

As we know, the dream is not governed by the temporal-spatial circumstances of the waking life. It gets right to the "heart of the matter" without regard for the perceptual niceties the ego is accustomed to. Eons become moments and moments become eons. Displacements and substitutions of all sorts occur. History returns with a presence heretofore unknown. So it is analogically with the schizophrenic patient. The psychotherapist is hardly prepared to follow until much later, if at all.

Above all, the psychotherapist represents the unconscious part of the schizophrenic's conscious. He is the medium through which the thesis of the unconscious is synthesized with the antithesis of the conscious. The psychotherapist is the patient's *other;* he is himself, but he is also a significant part of the patient. This is not only to be understood by introjection and identification; it is a present and past symbiosis rooted in the history of all mankind. It is the closest relationship of all, symbolically and in actuality. It is a commitment and affirmation of order.

The psychotherapist has, like the layman, tended to ignore the significance of the *moment* instead of capturing it. He seeks a breakthrough in *content-complex* rather than in *time-complex.* He clutches at his *time-oriented* existence and is frightened by the schizophrenic's boundless referrent. He cannot see the *moment-for-itself* in terms of his own immediate experience with his patient. He gathers *moments* while losing the *moment.* In his hypothesis making—preludium to interpretation —he organizes the patient's *time world* into his own and thus denies the encounter between them.

In Spain the bullfight is of tremendous personal and collective significance. It is not just a sport as is, let us say, football or soccer. The bullfighter and his role signify the game of life and death for the Spaniard, who must continually renew or affirm himself. In the bull ring a man faces, against great odds, a bull specifically bred for the instinct of destruction. There is no pretense in the ring, it is live or die, and the crowd will brook no displacements, sublimations, or other defenses. It is kill or be killed. The most sensitive and momentous part of this process is the *moment of truth.* In this *moment* either the bull is killed with one thrust of the sword, or the matador dies by a gore-thrust of the bull's horn. It is the *moment* in which man faces his greater reality, his instincts, by himself —unadorned except for a phallus— and must measure up. If he does, there is no greater acclaim and no greater feeling of self-esteem. The spectator is a deep participant in the process as the face and body language of the Spaniard reveals. In Spain, where life for the average man is very hard, the *moment of truth* symbolizes his humanity and high purpose in the face of a Nature which often fails to distinguish between its species.

The schizophrenic, too, has his *moment of truth.* This moment is apt to come with his psychotherapist at those turning points in analysis which we have all experienced with such patients. It is when the schizophrenic patient accepts the Absurd as his burden—as have all men—and continues in a culture which is often paradoxical and meaningless. This is when he encounters his psychotherapist as a fellow being in the full nakedness of person to person and is able to give and receive love. It is then that he makes his own existential choice at his *moment of truth.*

It is with only half humor that I say that hospitals which treat schizophrenic

patients should provide bullfights for them. It is one way to penetrate symbolically to the core of existence, and to be affirmed on the highest level of morality. Where in the United States in our mental hospitals are such opportunities so cheaply afforded?

The problem of the *moment* is an old one philosophically, but it has relevance to what we try to do in psychotherapy. Why, for example, are psychotherapists so preoccupied with the beginnings and endings of psychotherapy?[9] And why do they bog down in this phase more than any other?

It is not difficult to understand why these phases of analysis are so difficult for the psychotherapist. They are difficult for all men. To *enter* and to *exit* are existentially problems of the same order as *to be,* and reams have been written on the topic. They are of interest here because they relate to the *psychic time* of the schizophrenic patient and psychotherapist. To *enter* is to accept a burden for which the gratification may fail to compensate. To be committed to a *project* (in Sartre's terms) is both confining and transcending, but such commitments do not come easy. An ultimate reference, I suppose, is the commitment of birth; it is common for schizophrenic patients to wish they had not been born. At any rate, the original commitment of birth was both an insult and an opportunity. But it cannot obliterate the symbolic wish for non-commitment. In the psychotherapy of schizophrenia the *entry* is a most important *project.* Each participant enters the life of the other through a basic commitment of considerable scope. What this means exactly I am not certain, but it parallels the greatest *moments* and experiences in one's being. (I sit, for example, with my colleague in the family therapy of a schizophrenic patient and observe the patient who is now a person rather than a vegetable—integrated, poised, definitive—and a special feeling overwhelms me. It is, as I can best describe it, a feeling of standing in the face of a creation in which one has had a major part. I glance at my colleague and see that he has had the same emotional experience.) The *entry* with the schizophrenic patient is usually made quickly, *momentarily,* although hedged by many special but extraneous considerations. One knows, however, whether one wants to treat or not treat this patient rather quickly; but we cannot allow things to be this simple! Temporally, the commitment is enduring, without beginning and without end. All considerations of *time* are abstractive and for the convenience of the psychotherapist. There *is* no beginning, for somewhere in the past the patient has encountered the psychotherapist or his prototype, for otherwise a transference would be impossible. The patient then enters something already historically *de facto* and interprets it as such. (Schizophrenic patients are always wondering where they have met you before!) He wants only to assure himself that it is a continuation and that there will not be the abrupt *exit* which occurred before.

My temporal conceptions, while appearing impossible practically, are of the greatest dynamic significance for the treatment. They allow *entry* of one to the other on the only temporality possible to the patient. It places the stress on the *you-and-I-together-in-the-world* rather than on mediative properties which are obstructive because they are artificial. It allows the psychotherapist to draw upon his own humanity in the relationship rather than upon technical maneuvers oriented toward content. He can see the patient as a life in process in a world of his own making.

Schizophrenic patients have a "slimy" quality in that they stick fast to what they have. Disengagement is difficult and they tend to choke off with their "slime." This is frightening to the psychotherapist and poses the problem of eventual *exit*. My thesis is that there is no *exit*, that only as the patient *entered*, so will he *exit*. His relationship to the psychotherapist never stops, but its form is symbolized, displaced, substituted. As a man never really gives up the symbol of his mother, the schizophrenic patient similarly does not yield the treasure he has found in his encounter. *Exit* is, of course, related to the final one which sets the anxiety pattern for all *exit* facsimiles. With the schizophrenic patient this is much more critical, since he has already symbolically *exited* but has not had the courage for the final step, which would be death. For him, *re-entry* means *no-exit*, so he seeks an enduring relationship with his psychotherapist and with others. Under these circumstances, time-limited psychotherapy of the schizophrenic patient is a misnomer.

The reader will, by this time, possibly agree with the philosophical aspects of temporality presented here as they are related to the analysis of the schizophrenic patient. He will, however, say that practically it is out of the question. Many patients have to be seen and the psychotherapist is faced not only with earning a livelihood but with a proper use of his *time*. With this I must agree. However, it must be noted that even an attitudinal change in the psychotherapist is transcending, so that the relationship is already different and the treatment need not be forever. Those who treat schizophrenics analytically are select by their dedication and, if the values which make this possible are meaningful, then growth in temporality must be accepted. We must have room for these patients somewhere for as long as they need us.

We must become aware of the significance of certain *moments* in the analysis and be capable of experiencing them as well as interpreting them. In the history of man, *momentary* conversion experiences have often been decisive for man's history. Could it also be true for the schizophrenic patient—not that he necessarily has a conversion experience, but that *moments-of-being-in-the-world-with-the-psychotherapist* are crucial in determining his existence. I think so. Is it possible that the often routinized and lengthy path of psychoanalysis can be shortened by a better appreciation of the way-points in their fuller dynamic and temporal meaning? This is novel, but bears consideration.

REFERENCES

1. Burton, Arthur: "Schizophrenia and Existence," Psychiatry (in press).
2. The present emphasis on mathematics and quantification in our culture is directly related to *time-boundedness*. It is what existential philosophy seeks to counteract. Man's freedom must also be related to his conception of *time*. While mathematics gives us greater precision, it becomes more and more alienated from its object and, more seriously yet, the scientist himself falls a victim by partialing himself out of the total human scene.
3. Shlien, John: "What Length and Intensity for Psychotherapy?" Paper presented at the American Psychological Association, Cincinnati, 1959.
4. It is easy for the psychotherapist to believe that he goes on and on. There are a dozen plausible reasons he can give himself. It therefore comes as a considerable shock to all psychotherapists when a prominent psychoanalyst dies. Such feelings lend confirmation to our own involvement with *time* in a special way.
5. Burton, Arthur: op. cit.
6. I have borrowed this phrase from Jean-Paul Sartre in his *Existential Psychoanalysis*, New York, Philosophical Library, 1953.
7. This was reported to me by Dr. Harold Searles. The interpretation is mine.
8. "Relation of Time Estimation to Satiation,"

J. Exp. Psychol., 1939, 25, 281-293; "A Further Study of the Relation of Time Estimation to Monotony," J. Appl. Psychol, 1943, 27, 350-359; "Behavioral Characteristics of Monotony in Two Age Groups," J. Exp. Psychol., 1943, 33, 332-329.

9. My analysis of the addendum responses to case histories of treatment for a broad cross-section of psychoanalysts and psychotherapists indeed reveals that selecting patients for such treatment, and terminating them once the process has come to a conclusion, is a difficult thing. The practices are quite diverse. Cf. Arthur Burton (Ed.), "Case Studies in Counseling and Psychotherapy," New Jersey, Prentice-Hall, Inc., 1959.

KAREN HORNEY AWARD

The Association for the Advancement of Psychoanalysis wishes to announce that the recipient of the Karen Horney Award is customarily presented with the Award on the occasion of the Annual Karen Horney Memorial Lecture. The Award, in the amount of $150, is made for the paper deemed to have made a contribution to the furtherance of psychoanalysis. The Award Committee is evaluating current entries for the Award to be made in March, 1961. Authors who wish to enter their papers for the year 1961 should do so no later than October 1, 1960. All entries should be forwarded to Louis E. DeRosis, M.D., Chairman, Karen Horney Award Committee, 815 Park Avenue, New York 21, New York.

THE SYMBIOTIC MATRIX OF PARANOID DELUSIONS AND THE HOMOSEXUAL ALTERNATIVE

JAN EHRENWALD

OUR MODERN dynamic concept of paranoia and paranoid schizophrenia has evolved from Freud's analysis of a patient whom he never met in person: from the analysis of the celebrated Schreber case.[1] Nearly half a century has passed since its publication and one may well ask today what would have happened had Freud developed his theory of paranoid delusions on the basis of direct clinical observation, particularly in psychotic children of the symbiotic versus the autistic type, as they were described by Margaret Mahler,[2] Mahler and Elkish,[3] Mahler and Gosliner,[4] Leo Kanner,[5] and many others.

It is needless to say that the question cannot be answered on its own merits. All we can do is try to forget, at least for a brief moment, what we have learned from S. Freud,[1] S. Ferenczi,[6] G. Bychowski[7] and many others about the mechanisms of projection of repressed homosexual drives; about the introjection of parental images; the release and externalization of the introject, and so on and so forth. Having thus made our mind a blank (if this is altogether possible), we can try and look at our clinical material in a new light and draw our own conclusions. Once this is accomplished we may try to fill in our amnestic gap again and compare whatever conclusions are suggested by our data with more generally accepted propositions concerning paranoid psychodynamics.

Our first illustrative case is that of a pre-psychotic child and his obsessive-compulsive mother. Mrs. C., the mother, is a frustrated actress, a glamorous woman of 40, married to a rich banker 20 years her senior. The marriage was unhappy from the outset. Mrs. C. saw in her husband a revival of her own compulsive father, and her attitude toward him was one of childish dependence and rebellious defiance. Extra-marital affairs, alcohol, and occasional stage appearances were her outlets from what she felt was the golden cage of her married life. Their only child, Dick, was conceived when she was 36, during one of her affairs with other men. Mr. C. asked no questions and seemed happy to have become the

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Jan Ehrenwald, M.D., Prague, 1925; Departments of Psychiatry and Neurology, Universities of Prague and Vienna, 1925-31; instructor, Long Island College of Medicine and State University of New York, 1948-1952; attending psychiatrist, chief, Adult Psychiatric Outpatients Service, Roosevelt Hospital, N. Y. Author: *Telepathy and Medical Psychology, New Dimensions of Deep Analysis,* and of an historic anthology of psychotherapy, *From Medicine Man to Freud.* This is the revision of a paper presented before the Society of Medical Psychoanalysts at the New York Academy of Medicine, November 12, 1959.

father of a son so late in life. Mrs. C., in turn, hoped that with Dick's birth everything would turn for the better. Dick would bring at long last some purpose into her life. He would fulfill her own frustrated ambitions for a successful career. Maybe he would become an artist, a dancer, or an actor like herself. When the baby was a few months old she made Mr. C. move out of their common bedroom and installed Dick in his place. At the same time she became increasingly solicitous for the child's welfare. She did not let him attend kindergarten for fear of infectious disease. She kept him home on rainy days lest he catch a cold. Needless to say, Mr. C. was given no responsibility whatever in the child's upbringing. Dick remained under the sole control of his mother and his aged maternal grandmother, who had always remained closely, if not symbiotically, attached to her daughter.

Dick was a well-built, obese child, the "spitting image" of his mother. At three to four years he developed an increasing interest in women's underwear. He would sneak into his mother's dressing room and put on her brassieres and panties. Or else he would drape himself with her scarfs and dance in front of the mirror—sometimes under the admiring eyes of his mother and grandmother. He loved to play with the dolls his grandmother brought him; he took them everywhere he went and showed a variety of girlish mannerisms. Intellectually he was a precocious child. He had a large vocabulary and developed the habit of asking compulsive questions, such as, "Who is God?", "What is snow?" At three years he asked his mother, "Is daddy my real daddy?" Or he would say, "Yes, he is my daddy, but is he my real daddy?" While polite and well-behaved with strangers, he was most provocative and aggressive with his father. Like the neurotic children described by S. Szurek and A. M. Johnson,[8] M. Sperling,[9] and others, he seemed to act out his mother's repressed hostility against Mr. C. He would scratch, kick, and bite him, call him a pig, and threaten him with a knife. He would say, "You are too old for my mummy. She should divorce you".

Dick's destructive behavior was not, however, confined to his father. He wanted his mother's constant and undivided attention and flew into rages when thwarted. He drove nurses and governesses to desperation, forced them to quit. He would run in front of a passing car to taunt his mother. He would trample on her flowerbeds in the garden. He broke plate glass, mirrors, or her favorite antique furniture.

All this violent acting out did not, however, obscure one salient fact of Dick's personality development at that time: he had failed to establish his individual identity, sexual or otherwise, in his own right. Analytically speaking, his ego boundaries were merging with those of his mother. He remained an appendage to, or a direct extension of, her personality and he had apparently done so in compliance with his mother's overwhelming need to maintain exclusive possession and control over him. This is the well-known picture of pathological symbiosis between mother and child described by M. Mahler, et al.[2, 3, 4]

Symbiosis has been described as the psychological fusion and interpenetration of two individuals, or in the case of child-parent symbiosis, as a failure of their mutual disengagement. They form what Mahler[2] has termed the "dual unity" of mother and child, or what Therese Benedek[10] has described as the mother-child "unit." Kurt Goldstein,[11] focusing on "abnormal types of symbiosis," is inclined to attribute it to a deficiency in the infant's and the mother's mutual adjustment. In effect,

he considers symbiosis largely as an attempt to compensate for a faulty functioning of the mother-child unit.

Be that as it may, Dick's reaction to his mother's symbiotic control was not merely one of passive compliance and submission. In fact, it may well be that it is only owing to his growing rebellion against her that he was spared the fate of a full-fledged schizophrenic psychosis of the symbiotic type. On the other hand, it may well be that Dick's negativistic behavior, if carried to an extreme, might bring him closer to the autistic type of child psychosis described by L. Kanner,[5] and M. Mahler and her associates.[2] It will be recalled that children of the autistic type respond to all attempts at communication with parental figures or with their social environment in terms of total withdrawal or negativism, so as to protect themselves against the "invasion" of their ego by what Bychowski described as the parental introject.[7]

What, then, is the relevance of these observations to our issue? Despite vast gaps in our knowledge regarding the further development of psychotic children of the symbiotic or autistic type, they seem to build a bridge to two familiar schizophrenic reaction types in the adult. One type is the paranoid schizophrenic in whose delusional system the role of the omnipotent parent seems to be taken over by the patient's imaginary persecutor. The adult paranoic, like the schizophrenic child, reacts to his persecutors either in terms of autistic withdrawal or in terms of desperate resistance and rebellion, at times amounting to catatonic negativism or stupor. Alternatively, he may yield to their influences in terms of Bleuler's command automatisms, culminating in total compliance and surrender to some demoniacal external agency, influencing machine, or what not. Or else he may respond with delusional ideas of grandeur, mystic participation, recapturing the infant's experience of magic control over the symbiotic parent and the universe at large.

The following observation falls short of filling the gap between symbiotic child psychosis and paranoid schizophrenia in the adult, but it offers at least a clue as to the common denominator existing between the two. Allen is a bachelor of 29. He holds a job as an accountant and has only lately moved out from his parental home. His mother is a driving, compulsive woman, domineering and emasculating with her husband, over-solicitous and protective with her son. Like Mrs. C. in our previous example, she too kept her son away from the companionship of other children lest he be hurt by bigger boys. Allen was a sickly and dependent child. Up to the age of 16 she supervised his bowel movements, his bathing, and soaped and massaged him under the shower. Allen described his father as a non-entity. Once, when Mr. G. was taken ill, his mother cautioned Allen, "Don't show him any sympathy. He will be only worse for it." When Allen started to date, his mother warned him against the danger of venereal disease or of getting "hooked" by a girl.

His analysis soon revealed that Allen had never been able to accept the masculine role. His sexual fantasies involved women lying on top of him. He would be prostrate his legs spread apart. The woman would insert a syringe or an enema tube in his rectum —the way his mother used to do in his childhood. He would be helpless, tied up with ropes or strapped to the bed, unable to defend himself.

Allen remembered that his mother made no secret to him of her wish that he had been a girl. He was also aware of her consistent attempts to tie him

to her person as closely as possible and to remove him from whatever influences his father might try to exert on him. Allen's decision to seek therapy was the first major step he had ever taken without consulting his mother. The step was forced on him by his growing uneasiness and anxiety in relation to a "certain type" of men. One was Mr. X., a colleague in his office, who insisted on making friends with him, on inviting him for a drink in a bar or in his apartment. Also, Mr. X. liked to pat him on the back, to put his arm around him or to stare at him in a provocative manner. It was gradually dawning on Allen that Mr. X. was in effect a homosexual whose apparent friendly interest in him was due to ulterior motives. Yet despite Allen's studied reserve he was unable to shake off the persistent Mr. X. His colleague, he said, "was mother all over again."

Allen's pursuers were not, however, confined to the male sex. He complained that middle-aged ladies frequently accosted him in bars, drew him into conversations, tried to get him to dance with them, or openly propositioned him. Or else he felt they were watching his movements wherever he was, whatever he was doing. He remembered now that as a child his mother had given him the same feeling. He believed a camera operated by her was trained on him and microphones relayed to her his words or secret thoughts. His attitude toward the therapist was beset by similar fears. He wondered whether the sessions were recorded by concealed tape recorders; he was afraid he might be drawn into a relationship of dependence and control similar to that between his mother and himself.

This brief fragment from Allen's case history shows once more the crippling effect of prolonged symbiosis between a controlling, possessive mother and her offspring. In this respect Allen's case record seems to be a direct continuation of the case history of little Dick and his obsessive-compulsive mother. Yet while in Dick's case there was evidence of growing resistance against what in the literature has been described as the "schizophrenogenic" mother, Allen's response to her had been one of total compliance and submission. In his case there is indeed a direct linear connection between the early experience of an omnipotent parent figure and the subsequent development of a delusional trend in which the patient feels threatened and pursued by sexually aggressive women—or by men who appeared to be "mother all over again."

There is, however, another point of difference between the early symbiotic model of child psychosis, as it is illustrated by the case of Dick, and his presumed adult counterpart represented by Allen. Dick seemed to be acting out, like a hypnotized subject, his mother's destructive impulses directed against his father. At the same time he readily accepted the feminine role, as though he were indeed a direct extension of his mother's personality; as though ego boundaries between the two were virtually nonexistent. Allen's reaction to the same situation was one of passive avoidance followed by actual flight and escape. In some of his ideas of reference and delusions of persecution, the part played by the omnipotent and omniscient mother figure is unmistakable: contrary to the classical Freudian thesis, some of his persecutors are women, not men. Even the persistent Mr. X. is the patient's mother "all over again"—a derivative of the maternal introject.

Yet while this is true, we have also to account for the fact that since his early twenties the majority of Allen's detractors and persecutors had undergone a change of their sexual identity. They

were no longer middle-aged women, that is, the successors of his enema-wielding "phallic" mother. They were well-built, aggressive men in the street, in the subway, or like Mr. X.

What, then, is responsible for this striking shift from female to male persecutor in the clinical picture? Let us take another look at our material, while at the same time trying once more to disregard our familiar notions concerning latent homosexuality and the tendency to projection, denial, reaction-formation, etc., as the decisive factors in paranoid psychodynamics. I submit that Allen's fear of his male persecutors is an indication of his biologically determined need to assert and to maintain his masculinity; a measure of his perfectly legitimate reaction to the renewed threat of emasculation posed by aggressive men. Allen's feminine identification, the invasion of his ego by the maternal introject, prevented him from assuming the masculine role in both fantasy and real life. It is this predicament which accounts for his belated rebellion against his mother, as well as for his fear and resentment of women in general. Nevertheless, his real goal in life has remained to live up to his innate biological potential and to realize his masculine identity. It is a tragic paradox characteristic of a large number of patients of this type that their very rebellion against symbiotic bondage to the omnipotent mother may drive them into the homosexual position.

Put in a capsule, Allen felt like a woman in a man's body. This precarious position made men all the more dangerous to him. It turned the slightest hint of homosexual temptation into an overwhelming threat to whatever masculine aspirations were still left in his personality make-up. This is why he was perfectly right in stating "Mr. X. was mother all over again." Mr. X. held the threat of a second castration to him. This is why, seen from Allen's angle, his paranoid response to men made a great deal of sense after all. It was a necessary defense against a real danger threatening his precarious hold on the masculine position. Another alternative would have been to accept his feminine role without a struggle and to resign himself to the life of a passive homosexual. A third possibility could have conceivably been a pattern of borrowed, second-hand masculinity—the path chosen by those homosexuals who seek the love of well-built, aggressive men so as to take the place of their symbiotic mothers. Latent homosexuality, as a fourth possible solution, was not, apparently, a course open to our patient. But at present the psychodynamics of his clinical picture seem to come close to such an adjustment.

The vicissitudes of the struggle between these three or four alternatives are illustrated by the following observation. Leon, a married man of 31, is the son of a controlling, possessive mother and a weak, ineffectual father. Thus his family situation is much the same as that in our previous example. Following a number of homosexual affairs in which he was the passive partner, Leon tried to solve his problem by marrying an aggressive woman, two years his senior. He did his best to make a go of his marriage yet continued to resort to occasional brief homosexual "flings." However, when his wife became pregnant, Leon decided to make a final break with his past and never to get involved with men again. This ushered in a full-fledged paranoid reaction, in which he felt good-looking men tried to accost him, followed his movements, watched his facial expression, and made disparaging remarks about him. Feelings of depersonalization and derealization complicated the picture. Analy-

tical psychotherapy helped Leon to emerge from this paranoid episode and once more opened up to him the doubtful security of homosexual acting-out. In the course of two years following the start of his treatment, the same cycle of overt homosexuality, alternating with paranoid episodes, repeated itself three times. Observations of this type are well-known in psychoanalytic literature. G. Bychowski,[7] Sandor Feldman,[12] and others have published similar cases, though their patients did not exhibit the cyclical course seen in Leon's case.

How can these observations be reconciled with Freud's original theory of paranoia as it was developed on the basis of the Schreber case? A fascinating study entitled *Schreber: Father and Son,* recently published by William Niederland,[13] seems to me to provide an important stepping stone in this direction. On studying a number of books written by the older Dr. Schreber, the patient's father, Dr. Niederland found that the peculiar, faddish educational theories, and the unmistakably sadistic measures of mechanical restraint advocated by the father showed a striking correspondence with the bizarre masochistic content of the delusional system which was later described by the son. Dr. Schreber senior devised a variety of gadgets for maintaining "the straightest possible posture" while sitting, walking and lying; various braces as restraints for the head, arms and legs, etc. He proclaimed that "the ignoble parts of the child's nature must be weakened through great strictness." He considered himself a reformer and humanist whose efforts aimed "toward a better and healthier race of men." At the same time there is evidence that he himself had suffered from compulsions and "murderous impulses." Based on these data and on other supportive evidence, Dr. Niederland arrives at the conclusion that the son's delusional system was essentially derived from the introjected paternal image. It constitutes "archaic elaborations of certain paternal characteristics and processes—introjected early in life and later released" in the son's memoirs.

On comparing this carefully reconstructed picture of Daniel Paul Schreber's traumatic childhood experiences with the cases of Dick and Allen quoted above, the similarity of their underlying family dynamics is unmistakable. In both Dick's and Allen's cases, as in the Schreber case, we see an obsessive, compulsive parent assuming total control over their offspring, forcing them to live, act, and speak like a ventriloquist's dummy, with the respective parent pulling the wires, dubbing the voice, and providing the script. In Dick's case the child is acting out the mother's preconscious wishes and desires. He behaves, he looks, he dresses like a woman. He becomes the mouthpiece of his mother's unverbalized thoughts, the willing tool carrying out her destructive impulses against her husband. It is true that so far there are no paranoid features in Dick's behavior. He has not as yet shown evidence of experiencing her power over him in terms of magic control imposed by an outside source. He is still locked in a struggle of growing intensity with her, bent on disengaging himself from her grip, and on asserting himself as a personality of his own right—male or female, as the case may be.

Allen's example shows the vicissitudes of a prolonged symbiotic relationship between mother and child at a later stage. Despite their physical or geographical separation, Allen's mother still maintains her stranglehold on her son. The maternal introject is exercising supreme power over his life. She can watch his movements, read his

thoughts, control his actions from a distance. Although she has been replaced by a succession of male pursuers, she is in effect playing the role of the first major persecutor in his paranoid system, and his subsequent tormentors are fashioned after her image.

Evidently, Daniel Paul Schreber's father is the paternal counterpart of these "schizophrenogenic mothers"—a "schizophrenogenic father," as it were. He too exerted an overpowering influence upon his offspring. And here too one has the impression that the son's paranoid trend is the direct continuation of his early symbiotic bondage to an omnipotent parent figure, elevated to the status of an all-powerful divine agency. Thus, despite the patient's psychotic distortions, his paranoid system is anchored in what to him amounted to a genuine early infantile experience. One is reminded of Freud's statement: "Delusion owes its convincing power to the element of historic truth which it inserts in the place of rejected reality."[1] And to this Freud added the significant afterthought that in this respect the psychotic, like the neurotic, suffers from "reminiscences."

The part played by a symbiotic, potentially "schizophrenogenic" father in relation to a daughter is illustrated by the following observation. Mary H., a woman of 29, lost her mother at the age of nine. Even before her mother's death she had always been closer to her father. Mr. H. was a typical obsessive-compulsive neurotic. He personally supervised her bathing, dressing, toilet habits, and eating. During the meals he insisted on inspecting Mary's mouth after each course, to see whether she had properly chewed her food. She was toilet trained at the age of two, but started to wet her bed again after her mother's death, thus forcing her father to carry her to the bathroom every night once or twice. Mr. H. liked her to engage in boyish games and to pursue hobbies he was interested in. He gave her the nickname Mario. At 12 or 13, Mary developed a variety of obsessive-compulsive habits. She had to genuflect in the street, to count her steps, touch certain objects, etc. Other rituals were connected with toilet functions and food fads. When she was 17 her father remarried. She ran away from home and had a "nervous breakdown." An impulsive marriage to a fellow student was annulled after a few months. It was followed by thinly veiled homosexual attachments to older women. At the same time Mary complained that her personality had undergone a marked change. She felt she looked, talked, and acted like a man. She dreamed that "a little man" was inside her chest and said it was he who flew into a temper when she was angry in the waking state. She noticed that people in the street—mostly teen-age boys—were making derisive remarks about her masculine appearance.

Nine years of intermittent analytic psychotherapy were punctuated by several attempts at suicide, usually provoked by what the patient interpreted as major rejections by various paternal figures, including her analyst. Her transference to the analyst had all the hallmarks of her original symbiotic relationship to her father. "I will never break away from you," she said on one occasion. "I am now a part of you as I have been part of my father before I broke away from him. I have no identity of my own. Without him or without you I am empty space inside. So long as mother was alive, she and I lived together in an igloo, like the Eskimos, miles away from other people. After that it was father, now it is you."

With the disappearance of her paranoid symptoms, the dissolution of her

symbiotic "transference" neurosis had become the overriding concern of the treatment. She was gradually helped to realize that she had spent her life in the hopeless search for identity through symbiotic fusion with an alter ego. "I want a leave of absence," she declared one day. "I know I lean too heavily on you. I efface myself so as to be in your good graces, but now I want to shift for myself. I said I wanted to be a child. But I said it as a self-betrayal to please you. I was your ventriloquist's dummy; I had given you the strings and I said what I thought you wanted me to say." A month later she reverted to the same point. "I want to try my wings—here it's a dead end. Peter (her estranged husband) is coming back from G. Now it's a split allegiance: he or you. But I no longer feel compelled to stay with you. I know I have to leave you in the end. I want to leave without a handshake. I don't want your support any more. Yes, I no longer feel you push me out of the nest! I do feel I am getting mobilized to live again—to resume my marriage. I know I'll work it out better away from you than with you."

She did leave without a handshake and returned to her second husband. A year after termination of her treatment she is free from psychotic symptoms. She is anxious to have a child and tends to channel her remaining compulsive trend toward achieving this goal.

How do observations like these compare with Freud's original thesis concerning paranoid psychodynamics? First, they confirm once more his proposition that the patient's delusional system is centered about a regressively distorted parent figure. This is documented by a wealth of psychoanalytic observations, including Mary's and Allen's cases described here. However, Freud's hypothesis of an underlying bisexual or latent homosexual orientation with the tendency to denial, reaction formation, or projection need not necessarily be the only, nor even the principal determining factor. This is well illustrated by Allen's example. As a result of his total identification and merging with his symbiotic mother, men constituted not merely an imaginary but a real danger to him. His uncanny capacity to ferret out such dangers is also borne out by the information that his purported persecutor, the persistent Mr. X., happened to be a latent homosexual in actual fact. (Mr. X. had been questioned by the police, charged with having molested minors, and subsequently dismissed from his job).

If it is permissible to make a more general statement on the basis of such observations, it would be to the effect that the paranoid patient's professed hostility against his enemies is indeed more than a defensive maneuver used to project or externalize his own repudiated homosexual drives. It is a protective device to ward off actual dangers threatening his masculine identity. Put in other words, the existing threat originates both from inside his own personality and from his environment. It is a re-enactment of the past with the help of such protagonists in the outside world as happen to lend themselves to the role of the symbiotic parent.

The same applies, *mutatis mutandis,* to Daniel Paul Schreber's delusional system, although in his case the homosexual threat—and the danger of emasculation—emanated from his first persecutor, the patient's castrating father, and not from a controlling symbiotic mother. Seen from this angle, the paranoid patient's delusional system appears in a new light. It strikes us as much less irrational than when viewed from the angle of so-called ordinary common sense. It appears as a symbolically distorted version of what to the patient is

a self-evident and incontrovertible experience of his early symbiotic relationship with the dominant parent figure, who actually did exercise omnipotent powers over him—and over whom the infant himself felt capable of exercising well-nigh omnipotent powers.

Another point raised by our material concerns the problem of what in psychoanalytic nomenclature is described as ego development, or what other schools of thought refer to in terms of individuation, self-realization, or self-actualization. This aspect is thrown into sharper relief by the case of Dick and his symbiotic mother. Obviously, Dick's ego development and the delineation of his ego boundaries was greatly hampered by the invasion of his ego by a parental introject. Bychowski's graphic description has indeed proved its value in a vast number of clinical observations and in the dynamic understanding of a variety of cultural and anthropological phenomena. Yet on closer scrutiny of the symbiotic child-parent relationship of the type discussed here, one gains the impression that the parental introject is not merely a post-natal acquisition grafted on the child's personality structure at the early oral stage. Nor does it behave like some inert object—a marble or a safety pin —which he happened to swallow while mother looked the other way. In Dick's case, for instance, the clinical observer cannot help feeling that his mother had been part and parcel of his ego from the outset. She had been "there" all the time, forming the core of his innate hereditary equipment, uncontested by whatever paternal influences were impinging upon him in later life. Dick seems to be the direct linear continuation of his mother's personality—a trend which was subsequently reinforced by her continued narcissistic control over him. In this respect Dick's ego development seems to lend substance to the early medieval Christian doctrine of *traducianism,* that is, to the doctrine of the transmission of an individual "soul" from parent to child, in contrast to the *creationist* school which believed in the creation of every soul at the moment of conception.

Be that as it may, forced as he was to live a life in his mother's image, Dick has failed so far to attain his sexual identity, male or female. Indeed, his transvestism and other mannerisms suggest that he may well be destined to develop into an overt homosexual in later life. The significance of such a predicament, however, goes far beyond the possible development of sexual inversion or paranoid sexual metamorphosis. It may be at the roots of the schizophrenic patient's ominously "weak" ego and thus predispose him to his illness. Human personality reared in our culture has apparently no option but to be cast in the mold of either male or female identity. Whenever there is a conflict between biological endowment and sexual role which the individual chooses—or has been called upon to choose—he is bound to fall short of developing an autonomous ego in his own right and of living up to his personal destiny. Incidentally, this may account for the striking numerical preponderance of male over female schizophrenic children. Evidently, early exposure to an all-powerful symbiotic mother can be more damaging to the little boy than to the little girl. On the other hand, it is interesting to note that homosexuals frequently display a marked flair for creative self-expression, even though this may sometimes assume an obsessive-compulsive quality. I believe, however, that current psychoanalytic theories explaining this tendency in terms of sublimation or neutralization of aggressive drives tell only part of the story.

It may well be that the homosexual, blocked as he is in the most vital sphere of his individual development, tends to deflect and channel his creative energies into such compensatory pursuits of creative self-expression as acting, composing, painting, or writing. Hence, the many creative personalities among these emotionally stunted individuals.

Similar considerations can be applied to the Schreber case. Here, too, the patient was prevented from growing into an independent and well-rounded individual. Instead, he remained a carbon copy of his father throughout his life—or rather an exaggerated and pathologically distorted version of the paternal prototype—without a chance of striking out for himself in the quest for individuation. Thus, Daniel Paul Schreber's early symbiotic bondage to his tyrannical father has left an indelible mark on his mind and he was not far off the mark when he interpreted his submission and surrender to the older Schreber in terms of homosexual rape and fantasies of emasculation. Again, it is quite consistent with his early experiences when he felt that other figures in authority—e.g. his psychiatrist, Dr. Flechsig—threatened to usurp the same role in his later life. Seen from the patient's angle he had no option but to fight their sinister influences with the last ounces of his remaining ego strength. At the same time, the writing of his memoirs strikes us as the *ultimum moriens* in his struggle for self-expression and self-realization.

More generally speaking, patients of this type seem to be faced with two equally perplexing and, indeed, self-defeating alternatives: 1. compliance with the omnipotent parent figure leading to a passive homosexual pattern; 2. frantic resistance and rebellion as a defense against such a contingency, leading to regressive disorganization of the ego, to ideas of reference, and a paranoid trend. This is why their predicament can be put in terms of paranoia and its homosexual alternative.

There is one more argument that seems to lend some substance to the paranoid patient's delusional claims. I have pointed out in other writings[14] that such patients, under certain more or less precisely definable dynamic conditions, show what amounts to a striking telepathic sensitiveness to the thoughts and emotional attitudes of persons in their social environment. To be sure, Paul Daniel Schreber's grievances against the venerable Dr. Flechsig were of a purely delusional nature. But we have seen that Allen's complaints about his colleague, the persistent Mr. X., did contain an element of truth. Although this was unknown to our patient, Mr. X. was in effect a latent homosexual. Again, Dick's compulsive questioning, "Is daddy my real daddy?" seemed to verbalize with striking accuracy his mother's repressed thoughts concerning Mr. C.'s paternity, thoughts of which he could hardly have been aware by the usual channels of communication.

It can likewise be argued that the neurotic children described by Szurek and Johnson[8] and their associates, acting out their parents' antisocial tendencies, do so as a result of similar sensitivity to the unconscious mental content of a symbiotic parent figure. Indeed, it may well be that excessive sensitiveness to such influences—or else an excessive defensive reaction against them—lies at the roots of the two contrasting schizophrenic reaction types in both children and adults to which reference was made on an earlier page.

The significance of this aspect of paranoid psychodynamics, however, goes further than the controversial issue of telepathy and related phenomena. It

suggests that the pattern of intrapsychic communication characteristic of the mother-child dual in the early symbiotic period is in effect the embryonic model of communication in general. It is at the roots of man's original unity with his fellow men—of what Kurt Goldstein[11] described as "communion." It is the *fons et origo* of Harold Kelman's concept of communing,[15] of the existentialist thesis of man living in a *mitwelt* with his fellows, and it may be regarded as the prototype of the telepathy hypothesis as it is held by modern parapsychology. Seen in this light, paranoid delusions are in essence the regressively distorted counterpart of the early symbiotic model of communication. Thus, our model provides a bridge—or rather an area of contact and coalescence—between such divergent issues as the psychological aspects of parent-child symbiosis, paranoid delusions, and parapsychological phenomena.

Summing up, clinical observations ranging from the case of a pre-psychotic child and his symbiotic mother, and three analogous situations in adult patients, to Freud's Schreber case, are described to illustrate the part played by early symbiotic parent-child relationships in paranoid psychodynamics. In the light of these observations, delusions of persecution and grandeur appear as the patient's distorted interpretations of authentic early experiences of omnipotent control by a symbiotic parent figure—and vice versa. To that extent the paranoid schizophrenic, like the neurotic, is suffering from "reminiscences." The patient's unrelenting struggle to ward off such influences reflects his continued quest for individuation and self-realization. On the other hand, his failure to achieve this end and his surrender to a symbiotic parent figure may turn him into a passive homosexual. This is described as the paranoid patient's homosexual alternative. It is illustrated by a case in which periods of homosexual acting-out alternated with episodes of paranoid psychosis. Observations of this kind seem to vindicate some of the patient's paranoid ideas.

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Discussion

Gustav Bychowski, M.D., New York: If I start by professing my pleasure in reading and then, again, in listening, to Dr. Ehrenwald's paper, I can assure you that his giving much attention to my own work was not the only source of this pleasure. In addition to a narcissistic gratification, there was also an objective satisfaction in seeing an important and difficult problem approached and expounded in an extremely lucid and profound way.

Since it is impossible to do justice to all the problems raised by the speaker, and also since I subscribe, in substance, to all of his views, I shall limit myself to touching upon and to developing certain points.

It is clear that the problems we are confronted with in the case material presented by Dr. Ehrenwald deal, to a large extent, with the primitive archaic ego. For it is on that level of development that the ego operates with certain basic mechanisms, such as primary identification, introjection, projection, and denial on a large scale; it is also on that level that fusion with the essential parental (in most cases, maternal) figure plays such a predominant role. This symbiotic relationship is maintained at a very early stage of development as the only relationship possible. However, at later stages, it may still be resorted to by the ego which feels threatened by a fear of disintegration. The feeling of loneliness, the dread of being abandoned, the terror of being victimized by the dangerous outside world, seem to be warded off by maintaining a symbiotic relationship. I should like to remind you in this connection that some of the basic symptoms of the catatonic series, such as catalepsy and automatism of command, can be understood on the basis of the ego divesting itself, as it were, of its own power and submitting irrevocably and unconditionally to the outside will of a magically omnipotent person. Moreover, some of the opposite symptoms of the same catatonic series, such as negativism accompanied, at times, by insurmountable selective muscular rigidity, appear as the defensive reaction of an ego which feels threatened by absorption, or by fusion with a powerful external figure.

Some other symptoms of the catatonic and paranoid series, which have been described under the heading of mental automatism (Clérambault), such as ideas of influence, the theft or reading of thoughts, can be viewed as disturbances of the functions of the ego which have been taken over by external factors, since the ego itself feels too weak to call these functions its own. In these instances, Federn spoke of the de-egotization of mental contents which leave, as it were, the ego boundaries and thus become attached to other foci of action. I elaborated on these problems in some of my own writings, more particularly in my "Psychotherapy of Psychosis."

It is clear that in its desperate struggle to maintain its identity and its integrity, the weak, immature ego is like to fall, as it were, out of the frying pan into the fire. This happens, for instance, when the ego tries to assert or assume a masculine role without being equipped for it. Since, on that level, more often than not masculinity assumes the characteristics of primitive barbaric aggression, the ensuing fear of retaliation mobilizes castration anxiety and fear of physical disintegration.

Homosexual acting-out may originate, among other sources, in the wish to restore missing masculinity by attempting to absorb, assimilate, or incorporate the virility of another person which is accordingly over-estimated and admired. Beautiful literary reflections of this attitude can be seen in the writings of Walt Whitman. It is easy to see how this hopeful turning toward the masculine object may change into disappointment and dread of the object which has been made so powerful by the magic hopes of the homosexual lover. In this way—though it is obviously not the only one—the road may be paved for the paranoid delusion originating in homosexual love or unfulfilled expectations.

Particular mention should be made of the magic implications in certain instances of homosexuality, which have been elucidated by Nunberg. Here, homosexual acts,

with their great aggressive impact, serve the purpose of magically asserting the ego or strengthening it by contact with a supposedly stronger or even omnipotent partner.

Thus, we may say that among the various ways of relating to object and to the world at large, the original symbiosis can be repeated or attained in rare moments of communion and may be attempted in acts of love; some of the latter, however, originate in such archaic mechanisms and with such an inadequate equipment that they must result in various distortions and pathological patterns. The paranoid attitude and homosexuality belong in this series. One might then say that the paranoid delusion may be derived as an attempt at recreating the original symbiotic communion with a homosexual object, but with a negative sign.

Another important original experience of the weak ego is what has been called the weakening of psychic activity or of mental acts and what not infrequently appears as one of the initial schizophrenic symptoms; what may become elaborated in a paranoid delusion, as an idea of an external, powerful object depriving the ego of its own strength. The form in which this nefarious destructive activity takes place may, of course, assume various shapes which are well-known to us from clinical observation.

In studying various shadings of dependence between the ego and the parental object, we may speak of a broad spectrum starting with an almost complete fusion, as observed in seriously regressed patients, and ending with a relatively mature individual who is able to introject and to assimilate essential parts or aspects of parental objects, so that the basic introjects serve as the ego's cornerstones. Here then, the mature and strong ego is distinguished by the ability to externalize, at will, important parts of introjects and to find them in appropriate persons in the outside world.

In contrast to this, in various degrees of dependence, the ego is compelled to defend itself against introjects which it externalizes and projects onto the outside world—unless the original love-hate object is still at hand. With these objects then, the ego is bound to repeat some of the struggles which occurred in the early stages of development. The clinical examples so beautifully presented by the speaker demonstrate this struggle and the various mechanisms resorted to by the ego. One can clearly see how the paranoid attitude, as well as the homosexual longing or actions, originate in the same basic matrix of the original symbiosis.

Time does not permit me to enter into a discussion of the clinical material presented. I would like to limit myself to the case of Mary H. since I was privileged to see the patient in consultation. Here, we see that the emphasis was placed on the pathogenic role of the father who tried to mold his daughter according to his own pathology. The repetition of the symbiotic situation in the transference was particularly illuminating. It was revealing to see to what extent the patient's existence was distorted by her attempts to repeat, as well as to undo, the symbiotic situation. In particular, this proved to be the decisive factor in her marital vissicitudes. One should state in this connection also that the full grasp of the primitive mechanisms used by the patient in her struggle for and against her primitive identifications was decisive for the therapeutic outcome.

Finally, as a last remark, I would like to mention briefly the relevance of Dr. Ehrenwald's idea for the evaluation of the so-called existentialist point of view in psychotherapy. To be sure, the way the patient is rooted in his existence, or the way in which he exists in the world, is essential for his mental well-being. There is no doubt that so many of our patients suffer from a lack of communion with the world, or, to put it differently, from aloneness and isolation. Yet it seems evident that in merely pointing this out to a latent psychotic, to a desperately struggling homosexual, or to a compulsively promiscuous person, who in this way seeks to heal the deep break between himself and the community of man, is of no avail. This cannot be followed by any practical results unless the genetic point of view comes into focus; it can only be so if the original relevance and present irrelevance of the pathological mechanisms is demonstrated with great acuity.

HAROLD KELMAN, M.D., New York: I hope my comments on Dr. Ehrenwald's presentation will approximate the high level of his discussion remarks[1] of my paper, "Communing and Relating," published in the November, 1959, issue of the *American Journal of Psychoanalysis.*

Out of the structure, methodology, and frames of reference inherent in my comments, I hope the process by which I arrive at my position will become evident, where I stand with reference to Dr. Ehrenwald's, where we touch and where we pass at a distance.

What I start and remain with is the human situation, the unitary process in living, in which one or more persons of the same and different sexes and ages may be participating. This fact a succession of more and more comprehensive theoretical models are attempting to formulate and communicate. According to von Bertalanffy,[2] "There is quite a host of possible models to deal scientifically with the directiveness, organization, and teleology of biological phenomena and behavior," and I add, a host of non-teleological, non-dualistic, and non-Aristotelian ones as well, with which the first mentioned are not mutually exclusive.

The nature of whole human beings in the totality of their contexts cannot be generalized from an anatomical attribute or function like sex. "We do not know to what extent there is in man an inborn need either for a sexual object in general or for a sexual object of a particular gender. We do know, however, that the particular choice of object that is made is markedly influenced by the growing child's dependent relationship with his parents. In this sense, the ultimate choice of object is a learned pattern of behavior."[3] Kardiner further adds, "The Oedipus complex as used by Freud is not universal in the form of the Greek myth where the family conflict was between son and father for the love of the mother. The Egyptian myth, for example, emphasized sibling rivalry, because the family constellation was dominated by brother-sister marriage; the Hebrew myth, on the other hand, was dominated by the absence of a maternal figure and emphasized strict and total obedience to the will of the all-powerful father."[3] Bieber's scholarly "Critique of the Libido Theory"[4] clearly exposes its inadequacy. Freud's original hypothesis of an underlying bisexuality or latent homosexuality and of paranoia as derivative are not consonant with observable facts.

Comparative ethology and child-development studies have shown us the vastness and intricacy of what may be subsumed under learning. They reveal that early habits are very persistent and may prevent the formation of new ones. Secondly, early perceptions deeply affect all future learning. This concept raises the difficult question whether basic perceptions—the way we have of seeing the world about us—are inherited or acquired. Thirdly, early social contacts determine the character of adult social behavior. This is the phenomenon of imprinting. These studies also show that there is an optimal time for stimulating releasor mechanisms of innate patterns.[5]

In short, a human being taught to realize his possibilities at the optimal time, in the optimal human situation, will have been taught and will have learned to have predominantly healthy perceptions of himself and his world. For that optimal development to occur, according to Goldstein, organism and environment must be adequate for each other. In the case of the infant, the "other" must determine the nature of the stimuli that will effect optimal growth according to that infant's inherited potentialities. A stimulus is adequate when it is of the right quantity, the right quality, given at the right time, according to that child's unique rhythm, temperamentally and developmentally, and it must be within the amplitude which furthers his optimal possibilities. The permutations and combinations of these few variables regarding stimuli attributes which would adversely effect the development of the child are myriad. The results can be under, over, and/or distorted development of aspects of the infant's symbolic self.[6]

Man is the only symbolizing animal. From the moment of birth learning begins. Through immediate experiencing in human situations, of which the mother-child

unity, or communion, is the prototype, the child creates a symbolic self. It is an evolving, constantly developing and changing self-concept built up out of immediate experiencing. It contains the individual's concept of himself as a feeling, thinking, willing, acting being, his conception of his body, his conception of his organicity, of his sex, of his boundaries in a feeling, in a physical, in a willing and in an acting sense, his conception of his identity, his conception of himself as a person, as a person of a particular sex, as a member of a family, of groups, of a nation, and of a cosmos.

"The smiling of the infant is *released by a definite stimulus-configuration* rather than produced by another person."[7] Note that Goldstein refers to releasor mechanisms obtaining in a unitary human situation and not caused by a person or specific person. It is not the person who is that infant's biological mother who is crucial, but the total human atmosphere we call mothering. And there is adequate evidence to show that mothering can be communicated in the infant-world communion by one or more mothers, grandmothers, or sisters. In some cultures it is the wet nurse, white or black, and in others the father, grandfather, or older brother.

There is another kind of evidence that emphasizes the crucial effect of mothering, i.e., distortions of it, and that it need not be communicated by the actual mother. We have heard much about schizophrenogenic mothers. I am pleased to note that investigations are evolving toward focusing more on schizophrenogenic families—on total human situations in which a schizophrenic member appears.

Fifteen years ago I saw a 50-year-old man about his 17-year-old schizophrenic son. I kept feeling, "This is all wrong. The schizophrenogenic mother is this boy's father." He was the schizophrenogenic mother, as described, and, factually, down to the minutest detail, had been the boy's mother. The boy's mother was twenty years younger than his father, who treated her like a baby doll. Two years ago I saw my second schizophrenogenic mother, who was the father, and the picture, historically and clinically, was in every way almost identical.

There is another kind of clinical evidence that shows it is not the sex, but the who or whos who do the "mothering" who are crucial. I will now refer to a number of very sick patients who had many years of analysis with one or several analysts. Their histories, personal and in analysis, revealed that their whole life-space, their feelings and thoughts, were almost totally filled by one person. That person from birth had influenced them in adverse ways. Some always knew it and others only after years of analysis. The double-bind was obvious. These adults factually had so filled their life-space that there was little room for anyone else. "There is no reason to assume an inordinate need for 'symbiotic parasitic fusion.'" Goldstein adds, "This fusion is the effect of a *pathological reduction* of normal adjustmental behavior to the primitive (abnormal) turning toward behavior." On the infant's side there is "stimulus boundness" and on the mother's abnormal feelings in response in her infant's "sticking" to her. In his "Abnormal Mental Conditions in Infancy"[8] Goldstein further elaborates his differences with Mahler and Kanner regarding so-called autistic and symbiotic psychoses in children. I regret I cannot devote more time to Goldstein's organismic approach[9, 10] which in spirit, in method, and in the facts it brings out are so close to my own. His ideas on the abstract attitude are crucial for my concept of symbolizing. I agree with and have extensively elaborated[11] his statement that "communion is the basis of all communication, hence also of the communication that makes psychotherapy possible."[12]

To repeat, these people's world was filled with sick loving and/or hating, and alternately both in relation to one adult figure who might have been of the same or the opposite sex. Secondly, they factually had been damaged severely by these people. The paranoid exaggeration was based not on grains but mountains of observable fact.

A 40-year-old, borderline schizophrenic, paranoid woman, now in her sixth year of analysis with her third analyst, factually was beaten nightly by her father during her third year and was used as a servant, as

were her three brothers, the eldest a hospitalized chronic schizophrenic. She feared and hated him all her life. As she becomes stronger, the validity of her observations about her father become even more evident and with less paranoid distortion and exaggeration.

An elderly woman was told by her mother she was her favorite over her sisters and brothers. She has had many analysts over many years, and about nine years of analysis. Only in the last few years could she experience how much her mother factually hated and damaged her and how much she in turn hated her mother. At times, during sessions, in homicidal rages at me she experienced me as her mother. When she would come to, and see me as me and male, she would become terrified at the awareness of her distortion.

An elderly woman even after years of analysis had great difficulty allowing herself to experience the damage her father had done her, explicitly evident in his statement to everyone, as long as she could recall, "Meet my daughter Bobby, who is my favorite son." She was a tomboy, violently competitive with her brothers, and a virgin to her death.

The following facts I have from the father of the boy involved, from his brother, and, from the analyst who worked with the boy's mother. From birth she constantly physically and verbally stimulated him, constantly hovered over him through his adolescence, constantly gave him things and showed him off as an object. In his many years of analysis his associations were replete with being given and being taken care of. The dreams in which women, frequently his mother, are coming to him, doing for him, touching him and making themselves available, ran into the thousands. He is married to a very detached girl and is violently opposed to having children.

In her analysis, the mother of a psychopathic boy, with horror, anguish, sadness, and courage experienced, faced up to, and positively did something about her share in his sickness. She became aware, in great detail, how she taught, aided, and abetted her son to become a psychopath and act out her rebellious defiant anti-social tendencies which were deeply buried and only became evident after years of analysis.

But those people who are taught to be a certain way, or not to be a certain way—not a boy or like a girl, or not a girl or like a boy or even a neuter—are somewhat less tortured than those who seem never to be able to unify themselves in one role or pattern even though it may appear that they do. One young man, homosexual since his early teens, lived in a state of torture and of constantly feeling split, a split he tried to bridge by shuttling back and forth between his mother and father, factually and symbolically, trying to appease both, as they carried on a never-ending battle overtly and covertly. I can capsule his horror and his inner split by a lifelong nightmare. He is being asked to choose between two sets of parents who present themselves as his real parents. He knows one set is false. Undecided and in horror he awakens. To choose the false parents would mean losing his real parents and being left with the false ones. To choose the genuine ones would arouse the ire of the false ones who might kill him. As yet he has been unable to resolve this split, this dilemma.

The symbolic self and the self-system, as I have defined them, include all that is subsumed under the existentialist notions of *mitwelt, umwelt* and *eigenwelt,* and more. They have their origins in and derive from that organic matrix of which the mother-child unity or communion is the prototype. In the above cases, the world of each of these people growing up was filled by one figure. That figure filled their *umwelt, mitwelt* and *eigenwelt,* and more. It could not be otherwise than that the older women who accosted Dr. Ehrenwald's patient, Allen, in bars, and the persistent homosexual Mr. X. would be "mother all over again." His world of learned experiences knew only mother; and Paul Daniel Schreber's world understandably was filled with father and fathers who acted or seemed like father.

It cannot be otherwise than that these people growing up will have values identical with or in response to what was required by the significant other, to survive in the world of terror with which they surrounded

them. In such a terrifying atmosphere there will be little genuine development, much alienation, and much compulsive hating and/or compulsive loving. One crucial result can be identified. While complying, such children had to wipe themselves out and be what would insure survival, whether in the case of a male to be a not-boy, like a girl, or a neuter. One man whose compulsive homosexuality was worked through in analysis observed his mother with his infant son. It was just like she had been with him. She persistently, intensively, and demandingly, by voice, facial expressions, and touch, stimulated the little boy until he smiled, cooed, laughed, and ultimately screeched with pleasure. In this man's childhood and to date she is a domineering martyr. She destroyed his father in his eyes and isolated the boy from him. By her explicit and implicit attitudes she proscribed the things boys do, and circumstances forced him to play with girls which, in time, he preferred. Concisely the male world was interdicted and condemned and the female world provided and glorified.

Clearly, to comply is to be safe, is to be what the significant other requires. And not to comply is to invite that other's wrath, learned through a life of inextricable bondage. But what about the exaggerations of the importance of the other in adult life? I have mentioned how they fill that person's world, how with little genuine self-identity and great alienation the anxiety threshold is very low and the equilibrium of the neurotic defensive structure they have created is so precarious. All defenses are pride-invested. When threatened from within, self-hate is generated, and when from without hate toward the offender. When there is rebellion against complying, pride in that defense is threatened and self-hate follows. By a dynamic process Horney called passive externalization,[13] it is experienced as coming from without. The dynamism explains part of the feared assault from the ubiquitous and omniscient significant others who factually so warped the lives of these people.

I hope I have indicated enough of the spirit and facts of my ways of thinking, and of how they specifically relate to Dr. Ehrenwald's presentation, to have made it evident where our positions meet and pass at varying distances. I want to thank him for the opportunity to discuss his paper, which represents one more step in the evolution of his ideas—ideas I have followed with interest and profit in a sequence of papers over these past years.

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CULTURAL FACTORS IN PAYMENT FOR PSYCHOANALYTIC THERAPY

DANIEL N. WIENER AND OTTO N. RATHS, JR.

INTRODUCTION

THE SYMBOLIC and motivational significance of payment for psychoanalytic therapy has been discussed by several writers including notably Freud,[1] Fenichel,[2] and Kubie.[3] Seldom have the cultural factors related to payment received equal attention. Generally, the giving and withholding of payment has been described in terms of "instinctual drives" involving orality, sexuality, and anal-sadistic strivings. Freud[4] has also discussed the secondary gain aspects of psychoanalytic therapy, and difficulties concerning payment which can arise on a realistic basis between therapist and patient.

No one, however, appears to have described the full impact of cultural factors on the significance of payment in psychoanalytic therapy, or to have structured the meaning of payment within the framework of relationship between conflict and civilization described so well by Horney:

"The kind, scope, and intensity of conflicts are largely determined by the civilization in which we live. If the civilization in which we live is stable and tradition-bound, the variety of choices presenting themselves are limited and the range of possible individual conflicts narrow. . . . But if the civilization is in a stage of rapid transition, where highly contradictory values and divergent ways of living exist side by side, the choices the individual has to make are manifold and difficult."[5]

The conflicts about payment to which our particular civilization gives rise revolve essentially around the question of who shall pay for treatment. Should it be the individual patient who, since he pays for most of his other personal services in our mainly capitalistic society, might feel uncomfortable, inadequate, or dependent, if he does not buy his own psychoanalytic services? Or should it be paid for by the community, or state or Federal government, as part of its responsibility for the maintenance of the health and welfare of its citizenry?

Obviously, different cultures can produce different areas of conflict. We would assume that in socialistic England the conflicts about payment would be minimal, since few alternatives to public services are available to any but the wealthy. In the United States, the Horney hypothesis suggests that the conflict would be somewhat greater, since, although we are committed primarily to the capitalistic system, our competing public social services are in-

Daniel N. Wiener and Otto N. Raths, Jr., are associated with the Veterans Administration Mental Hygiene Clinic, St. Paul, Minnesota, and the University of Minnesota.

creasing rapidly, particularly in the mental health field.

It is our purpose in this paper to review the symbolic and cultural significance of payment, and to attempt to restructure present concepts about payment in accordance with the Horney theory of conflict.

Symbolic Significance of Payment

In the modern era of psychoanalytic therapy, the symbolic significance of money and payment for therapeutic services was first emphasized by Freud and, in continuity with him, by the more orthodox analysts.

Fenichel summarizes the literature on the meaning of money in psychotherapy this way: "Money and feces have in common that they are deindividualized possession; and deindividualized means necessarily losable." Thus money "is estimated and watched over . . ." but also "regarded with contempt because of (its) deindividualized, monotonous, unspecified nature. . . . When the sublimation of money as a substitute for shiny things and stones is disturbed because the old instinctual wishes referring to feces still determine the attitudes toward money, the attitudes toward money become irrational."[6] Again, "Generally, all capitalistic society, by preparing the children for the role that money and competition play in their life, favors the intensification of anal-sadistic strivings. This is the more unfavorable as simultaneously genital sexuality is discouraged and frustrated."[7]

The acute sensitivity surrounding the consideration of money in our society is put this way by Freud: "The analyst does not dispute that money is to be regarded first and foremost as the means by which life is supported and power is obtained, but he maintains that, besides this, powerful sexual factors are involved in the value set upon it; he may expect, therefore, that money questions will be treated by cultured people in the same manner as sexual matters, with the same inconsistency, prudishness and hypocrisy."[8]

The patient may pay too low a charge by lying about his income,[9] or may offer expensive gifts to try to insure affection or reduce threat. On the other hand, the therapist may charge too much because of a neurotic interest in money,[10] or too little, because of countertransference.

These views of the symbolism and uses of money payment have remained essentially unchanged from Freud to the present time. Their roots are said to be found in primitive anthropology, and to remain now in the deepest, most insulated recesses of our psyches. They are said to describe aspects of behavior beyond our control and likely to prove enduring in mankind.

Freud, perhaps earliest and most clearly, described the motivational significance of money payment for psychotherapy. Of the therapist's motivations, he wrote: "In my opinion, it is more dignified and ethically less open to objection to acknowledge one's actual claims and needs rather than to act the part of the distinterested philanthropist, while that enviable situation is denied to one and one grumbles in secret, or animadverts loudly over the lack of consideration or the miserliness shown by the patients."[11]

Glover, describing the results of that section of his questionnaire to all English psychoanalysts concerning fees, wrote that "there is much more hesitation to apply rules strictly . . . than there is in the case of time arrangements"; and that "answers to these questions of detail were much less free and voluminous than when the issue appeared to touch more obviously on

the technical principles."[12] He suggested that this might be because more guilt feelings are aroused by questions about fees. Wolberg[13] also refers to too low a fee as making the therapist feel "insecure," "resentment," or "anxiety."

Freud, after mentioning how he had tried to help patients gratuitously, stated: ". . . the advantages which I sought in this way were not forthcoming. Gratuitous treatment enormously increased many neurotic resistances, such as the temptations of the transference-relationship for young women, or the opposition to the obligatory gratitude in young men arising from the father-complex. . . . The absence of the corrective influence in payment of the professional fee is felt as a serious handicap; the whole relationship recedes into an unreal world; and the patient is deprived of a useful incentive to exert himself to bring the cure to an end."[14]

Freud plumbed "for hire by the hour."[15] Wolberg agrees, but only that it is "best" as a "general rule."[16] Freud went on to say that he "regrets that analytic therapy is almost unattainable for the poor," partly for external reasons but also because ". . . in this class, a neurosis once acquired is only with very great difficulty eradicated. It renders the sufferer too good service in the struggle for existence. . . . The pity which the world has refused to his material distress the sufferer now claims by right of his neurosis and absolves himself from the obligation of combatting his poverty by work."

Very recently Kubie has reviewed and repeated these views of Freud on behalf of current analytic practice, without, however, accepting Freud's statement about working with the poor or the failure of free treatment.

Though Kubie does mention "the . . . accusation . . . that the analyst is unconcerned with the welfare of the poor," and that his social and economic attitudes will be colored ". . . by contact only with a wealthy clientele," he concludes that "none of this is true; but even if it were, it would concern only the facts of psychoanalytic practice in our present economic system . . ."[17]

Kubie also treats of the argument that ". . . an analysis for which a patient makes no personal financial sacrifice is foredoomed to failure."[18] He states that while a patient may exploit a therapist's generosity, and receive neurotic gratification, usually such ". . . generosity bears fruit in the end."

Cultural Significance

So far, the factors concerned with the significance of payment have centered about conflicts internal to the individual patient, or between him and his therapist. Primarily, either "instinctual" strivings have been involved, or personal motivations.

Obviously, however, there are extremely important aspects to the meaning of payment which involve its meaning in our particular culture. Although money may have some similar, universal significance in all cultures, as may also the relationship the individual patient tries to have with his therapist, it seems obvious that the strength of individual needs, and the desire to pay or not to pay for one's own treatment, will be greatly affected, if not determined, by the social system under which one lives.

Thus it seems extremely unlikely that, in a completely socialistic state where no services are personally purchased, persons seeking therapy would ever consider paying for it personally, or would ever be faced with the necessity of personally paying. Conversely, in the American society of thirty years ago, practically no one would have expected

to have therapy except by paying for it personally. In either case, conflict about payment should be at a minimum, since alternatives were not readily apparent.

Currently in America, however, we believe that conflict in the area of payment is accentuated by the steady increase in social and psychotherapeutic services provided free of charge, or at very low cost, to an increasingly large part of our population; while at the same time the private practice of similar services flourishes and expands. In the Horney theory of conflict, this situation, presenting strong alternatives, would accentuate conflict in the individual trying to decide between the private services and free public services. Concern with the factor of payment would be particularly acute if he were neither very wealthy nor very poor, either of which conditions would reduce conflict since the alternatives would appear to him of unequal strength.

One area in which the conflicts are pointed up is in the public or semi-public agency providing treatment, which considers or initiates the use of fee payment, not because it is financially necessary, as it is to the private practitioner, but rather as a transplant to a public agency of a presumably successful factor in private practice.

Boggs[19] claims that this practice stems not from theory, nor from professional persons, but from the insistence of clients themselves on paying for such services. In our culture, she goes on to say, a person pays his own way, and only services universally recognized as essential to all are tax-supported. She points to a substantial increase of agency clients in the higher income brackets as indicative of how a community agency can get away from the welfare concept. Eaton[20] bears out this latter observation with figures from the Family Service Association of Cleveland, which show it to be serving a clientele whose income distribution even in the upper brackets is almost identical with that of the county as a whole.

For better or worse, this seems to be the emerging pattern in clinics and agencies. Lamson,[21] in his 1955 review of fee-charging practices in mental-hygiene clinics, finds that a sharp increase is occurring in numbers of clinics and family service agencies making charges for their services. Up to seventy per cent of clinics surveyed in 1949-50 did so, and the number of family service organizations doing so rose from two in 1941, to sixty-one in 1950. Most such organizations use a sliding scale based upon income and size of family.

Based upon his review, Lamson cites one further reason for individual payment that concerns us here. It is that by having the clinic patient-supported financially, at least in part, the "consumer group" will keep the clinic more responsive to patient and community needs.

The difficulty of serving those who receive secondary gain from their care —who find relief from their troubles through being pitied and cared for psychologically, rather than through trying realistically to better their lot directly through their own labors—has its most valid contemporary counterpart in the growing problem of treating those people who make financial gains directly from their symptoms.

Dancey[22] has described how Canada tried to meet this problem with its post-military population by putting compensation for neurosis on rigorous grounds of proof, but providing treatment on much more lenient terms, thus trying to keep the two separated in as many cases as possible.

In their survey of 100 consecutive

patients coming to three eclectic psychiatrists in what they suggest is a typical private practice, Rickles et al.,[23] point out that most of the clientele is middle-class, sacrificing financially, though not excessively (an average of $240 per year) for treatment, and glad not to have to go to a state mental hospital. With evening clinics for persons who cannot leave work, reduced-rate day clinics for poor people where tyro therapists can practice under supervision, and greater inclusion of at least short-term psychotherapy in prepaid health plans, they imply that the problem of payment could be solved by private practice.

In 1951, Muncie and Billings[24] surveyed all psychiatrists partly or wholly in private practice, and found that, on the average, they devoted twenty per cent of their time to patients who paid nothing. Of those who were expected to pay, only two per cent of potential income was uncollectible. In a more inclusive study by Davidson,[25] reported in 1956, it was found that only nine per cent of psychiatrists' bills were unpaid, compared with fifteen per cent for physicians not psychiatrists. In addition, Davidson found that those psychiatrists practicing the most intensive (and expensive) treatment had less trouble collecting than the others.

One other comment by Davidson is noteworthy here: "Until recently most psychiatrists were in hospitals, agencies, and clinics. In 1954 for the first time the number in private practice exceeded the number in full-time salaried positions."[26] In other words, in this field the United States seems to be moving, if not in an opposite direction to England, at least in a more mixed way, suggesting the pre-potency of social and cultural forces in determining trends in payment for psychotherapy.

A New Structuring of the Significance of Payment

Conflict, and particularly the conflicts to which civilization gives rise in the individual person, is the starting place of our attempt to restructure present concepts of the significance of payment to psychoanalytic practice.

The universal meanings of money itself; of giving and withholding in any therapeutic relationship; of money to motivation where money may be viewed as punishing or rewarding, like any other kind of external reward or punishment, will not be our primary concern. This is not because we consider these aspects of payment to be unimportant, but rather because we think the conflict of which Horney has written is the most neglected aspect of the problem, and the most amenable to further adaptation and change in the interest of improving psychoanalytic practices in our present society.

Because of the variable structure of payment for psychoanalytic therapy within our culture, and the vacillating concepts of the importance of payment, an additional conflict of serious proportions is artificially imposed on the therapeutic setting.

Society has already decided that serious, chronic illness of frequently long duration, such as schizophrenia (and tuberculosis), is the responsibility of the community. We are, however, in a phase of transition and of marked intracultural disagreement concerning the other major groups of psychological reactions. This turmoil begins with the extremely complicated attempt to determine who should pay fees, and how much, based upon income, station in life, seriousness of illness, historical background, and even political considerations. In addition, we are extending these conflicts by attempting to de-

cide what categories of psychoanalytic therapists are entitled to accept fees or do free or reduced-fee treatment, and under what conditions.

Such areas of choice offered by the culture make it, on many occasions, extremely difficult for the psychoanalytic therapist to choose a social setting in which to work, and for a patient to select the therapeutic setting in which he feels he belongs, without a great deal of personal conflict. In our opinion, such conflict could now be eliminated in the United States only through the establishment of artificial subcultural groups for both therapist and patient, isolated from the general cultural pattern. Analysand and analyst would have to ignore the social forces giving rise to free or reduced-fee treatment; and public or quasi-public clinics would have to construct a world of their own in which patient and therapist would be immune to the competitive striving forces of our present society. The compromises, such as reduced-fee treatment by certain analytic groups, and token-fee payment in public or semi-public agencies are stopgaps which, we maintain, do not vitally affect the basic issues.

It is our opinion further that, until there is a resolution of this cultural conflict in our society as a whole, many people will be deprived of the benefits of psychoanalytic therapy, or are less effective even though in treatment or already treated. Treatment will be chosen, rejected, considered, and not considered, on the basis of these conflicting attitudes and practices regarding payment, which, in great measure, should be irrelevant to the basic issues corncerning mental health.

Hypothetically, we would assume that in other cultures, where many of the conflicts surrounding the payment of fees have been simplified or eliminated, regardless of the direction of resolution, either by community or individual responsibility for payment, psychoanalytic therapy would be predominantly more successful. This would also apply where direct tangible rewards for psychological symptoms or defenses are rigorously controlled. This concept, we feel, could also be applied to unconscious resistance related to the significance of payment, making it more amenable to change in therapy when the cultural conflicts are resolved.

Cross-cultural research concerning the payment of fees, involving the cultural interactions of both analyst and patient, should yield data sufficiently significant to permit the initiation of more realistic programing for mental health, and a potential structure for therapy where unnecessarily vitiating social conflict would be reduced or controlled.

Summary and Conclusions

1. The symbolic and motivational significance of payment in psychoanalytic therapy has been discussed in the professional literature, but the cultural significance of, and conflicts surrounding such payment, have been neglected.

2. Horney provides a theoretical structure for interpretation of the cultural significance of payment in terms of choices offered by the culture and the personal conflicts to which such alternatives give rise.

3. We have attempted to apply the Horney concepts in a way that places problems concerning payment in the perspective of our particular culture, and to suggest that (and why) conflict surrounding payment may be considered maximal in contemporary United States society.

4. By conducting extensive further research into the problem, and programing in accordance with its find-

ings, it is suggested that an important area of conflict in psychoanalytic therapy could be reduced or controlled, with consequent improvement in the quality of treatment.

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VARIATIONS IN THE DYNAMICS OF THE ANALYTIC RELATIONSHIP

IN THE CLINIC AND IN PRIVATE PRACTICE

CAMILLA M. ANDERSON

FOR MORE than twenty years I have practiced analytic psychotherapy. Approximately half of this time I have been in full-time private practice; the other half I have devoted full-time to clinics. Periods of private practice of two to five years have alternated with clinic practice of two to four years' duration. I have been engaged in both clinic and private practice in several localities: large urban centers, medium-sized cities, and small towns in various parts of the country—Philadelphia, Washington, D. C., Salt Lake City, and Salem, Oregon, among others. Except for three clinics in which I worked on a part-time basis as a member of a teaching faculty, every clinic position has meant full-time paid employment. The clinics have been under the auspices of colleges, cities, states, the Veterans Administration, and a Community Chest. With this diversified experience I may perhaps look at clinic relationships with a somewhat broader viewpoint than if I had been continuously located in one area or with one type of sponsorship.

Because in the clinic the patient load is too heavy and the waiting lists are too long, there is rarely time for long-term, intensive psychoanalysis. I shall therefore assume that the term "analytic relationship" refers to the doctor-patient relationship whenever the doctor is involved in practicing analytic psychotherapy, irrespective of the time factor, and this type of therapy will be the basis of comparisons I shall make.

There are several possible sources of variations in the analytic relationship in clinics and private practice. One source of difference might relate to techniques employed; a second might derive from the environmental factor; a third might have its source in the patient, and a fourth factor could be the therapist.

In many clinics it is routine procedure to have the patient initially interviewed by a psychiatric social worker to determine one or more of the following items: 1. suitability of the patient's problems for clinic services; 2. readiness of the patient for treatment; 3. pertinent historical data; and, 4. financial status. Only when the patient is considered suitable for treatment does the therapist appear on the scene, and often not until there has been an "intake conference," when the patient is assigned to the therapist for treatment.

This procedure, carried out under the banner of "the team approach"

Camilla M. Anderson, M.D., is director of the Out-Patient Clinic, at the Oregon State Hospital, Salem, Oregon.

tends, in my opinion, to be cumbersome, confusing to the patient, and highly wasteful of time. However, the very word "analysis" tends to be invariably associated with the implication of endless time, so this "time-wasted" factor is taken for granted rather than regarded as a serious defect in technique.

In private practice there is less time waste and less confusion for the patient because one person alone, the therapist, sees the patient and makes the determination as to suitability and readiness. Historical data immediately become woven into the fabric of relevance and therapy.

In at least one analytically oriented clinic the team-approach intake process is bypassed because every member of the staff is deemed competent to deal with the presenting problem or to make prompt and proper referral. In this university clinic it is my understanding that not only have waiting lists been eliminated by this procedure, but the average number of sessions of therapy peaks at eight. In other clinics, not organized in this way, there tend to be two peaks, one at two sessions (wherein the patient never gets beyond the intake interviews), and the second peak at approximately 40 to 50 sessions.

This discrepancy in number of sessions must imply some variation in the dynamics of the analytic relationship between the two types of clinic, and it would be my guess that two of the factors involved are the unfortunate effect of the routine intake process, and some particular mind-set of the therapists. It seems unlikely that it can be accounted for solely by differences in types of patients or their problems. However, the fact that this particular one is a university clinic and is being compared with clinics in general suggests that there may be a true difference in the types of patients frequenting them.

The factor of choice of therapist might well be supposed to alter the analytic relationship in clinic, as compared with private, practice. The supposition that liking the therapist will favorably affect the outcome of therapy, or even speed it up, is, of course, not well-founded. There may, in fact, be an initial handicap under which a "chosen" therapist has to operate which does not impede the "assigned" therapist. Likewise, if it appears that choice is so important to the patient, one may have stumbled upon a significant detail in his scheme of values which has relevance to the entire analytic process.

The presence in the patient of warm and accepting feelings, or their absence, is not important in itself. A more important detail is the finding of warmly accepting or rejecting feelings in the therapist as he engages in therapy. If I find myself thinking judgmentally or moralistically about a patient, I cannot be objective and therefore cannot help him. This indicates clearly that I have not shed my neurotic assumptions and will be involved with insurmountable counter-transference problems. Warm feelings are the by-product of successful therapy.

Some maintain that the clinic lacks the essential personal element as compared with private practice and that clinic patients therefore are at a disadvantage. Since one element in this personal feeling derives from stability of location, a clinic which is so organized as to require the therapist to shift from office to office for available space would encourage an impersonal feeling to be maintained. It is interesting to note how a certain room or a certain door come to mean "the clinic" or "my doctor" to a patient, and how the coming and going of many other patients and staff members is essentially disregarded.

If this feeling does not develop, one ought to look for the reason for the less personal feeling elsewhere than in the clinic itself. The basis of the impersonal feeling may lie in the characteristics of the particular patient. It is not uncommon for people who do not make a financial success of their lives also to have difficulty with personal relationships—not necessarily through hostility or resentment, but by reason of their inadequate capacities for empathy or even for sensing the feelings of other people.

A further basis of an impersonal feeling in clinics might be found in the particular attitudes of the therapist or in the techniques he employs. One type of approach is not equally suitable for all cultural levels. If the therapist is troubled by rigidity in his technique (since to vary would be "wrong"), a high proportion of clinic patients would scarcely feel much personal involvement. Again, the personal feeling may fail to develop if a young therapist is going to report on the session to his supervisor, or if an analyst in training is primarily focused on bits to be analyzed. If the impersonal feeling persists it may suggest that the sessions are essentially meaningless to the patient, and that there is a lack of involvement on the part of both.

Occasionally one finds patients who are concerned about the confidentiality of the clinic sessions. In private practice such concern would quite properly be scrutinized for its paranoid implications. When it occurs in the clinic it has been my experience that, while it is not an insurmountable problem, it may call for some factual reassurance, as well as regarding it as grist for the analytic mill. This point of confidentiality arises frequently in teaching clinics where one-way windows are obvious. Usually a patient soon becomes comfortable and goes on untroubled.

I am reminded of the comments Dr. Florence Powdermaker made years ago when she was involved in a teaching project wherein sound movies were made of her and her patients in therapy sessions. It was her expressed opinion that they were both so totally engrossed in their session that they were oblivious to what was going on around them. One cannot help wondering whether the adamant resistance to lack of complete privacy in therapy sessions might stem as much from the therapist as from the patient!

Aside from differences in environment and in technique, there does tend to be a difference between clinic patients and private patients when they are considered as a group. More private patients than clinic patients are suitable for analytic psychotherapy. This may not be too apparent when the job of screening has been accomplished before the doctor sees the patients. If he sees all incoming patients it soon becomes apparent that the proportion of suitable patients is higher in private practice, particularly if one's practice is limited to the practice of analysis.

This difference is not surprising when one considers that the same kind of capacity, namely, integrative capacity, is a necessary ingredient both for financial competence sufficient to be a private patient, and for making use of analytic psychotherapy. The reverse of this is also true, that people who have difficulty in the area of conceptual integration and who for this reason do not draw the logical or obvious conclusions, and therefore are poor candidates for analysis, are also the ones who are most likely to be fringe people economically. This is not to say that poor people are stupid. People may be poor for a variety of reasons.

What I am trying to say is that the

circumstance primarily responsible for the marginal economic state of many people may be their defective neurologic equipment rather than their psychodynamic problems. Many apparently bright people are actually very handicapped intellectually by reason of a defect which makes them concrete rather than abstract-minded, perseverative where they need to be free to shift, impulsive because they deal with partials rather than with wholes, anxiety ridden in unstructured situations, and fragmented where they need perspective.*

I realize that this is not a prevalent point of view, and it is one that will arouse a measure of resistance in those not familiar with the characteristics associated with certain types of minimal brain deficit. It is my opinion, however, that we are on the threshold of a new awareness in this area, and that this new perceptivity, fortified by increasing assistance from psychology, will make some noticeable change in therapeutic techniques, as well as in psychodynamic conclusions and interpretations. It is my experience that many aspects of behavior are indiscriminately considered to be psychodynamic in origin and nature because the therapist has not yet incorporated a broader understanding of behavior into his evaluative armamentarium.

A further difference in patients, if one is to accept the statements of many therapists, is the greater prevalence of guilt in clinic patients as compared with patients in private practice. As I understand it, the guilt is interpreted as stemming from their not paying the fees for services they would ordinarily pay if they were private patients. By reason of this prevalent guilt the analytic relationship is somehow different.

Since my experience is not in agreement with this finding it warrants closer scrutiny. It could be that I have failed to see guilt when it was in fact there, but other factors may also have operated to bring about this negative finding. One factor might be a basic difference in conceptual thinking regarding what other therapists and I would interpret as guilt. I am always surprised to find that what I see as a way of behaving so as to avoid or prevent or preclude a feeling of guilt is seen by others as evidence of felt guilt. It is only when the patient fails to carry out the behavior which protects him from guilt that I can consider him as feeling guilty. With such a viewpoint it is clear that many patients seen as guilty by other therapists would not be so viewed by me.

There is no reason why clinic patients should not be loaded with guilt, just as private patients, and some of them are, but I do not see this as primarily related to the non-payment of fees. Increasingly, guilt has come to mean to me a sense of self-rejection because of failure to have achieved the impossible. Rarely do I see guilt as the product of failure in realistic situations. People having failed to act in a realistically possible manner feel regret—not guilt.

Along with guilt arising out of an inner need to be and do the impossible, one finds other well-known symptoms, such as depression, helplessness, paralysis in living, alcoholism, self-pity, sensitivity, withdrawal, and rage. These seem invariably to arise from overvaluation of the self, and the entitlements,

* For those who are interested to know more about the behavior characteristics of people having the type of neurological deficit to which I refer, see "The Brain-injured Child with Behavioral or Perceptual Impairment. First draft Bibliography," Association for the Aid of Crippled Children, 345 East 46th St., New York, N. Y., 1959; also *Beyond Freud*, Anderson, Harper and Bros., 1957.

expectations, and demands which are an integral part of this basic (not secondary) self-inflation. Only the one who takes it for granted that he *should* be without fault or error will mope about or wring his hands because he is only human and therefore cannot achieve the impossible. In other words, I see guilt as one by-product of primary grandiosity.

A sense of entitlement, the antithesis of guilt, is a common finding in both clinic and private practice. The bases for this sense of entitlement vary from having paid taxes, to having fought for their country, to being poor, to being miserable and sick, to having paid their bills, to being or doing anything one may conceive of. There are always specific assumed entitlements present which vary from person to person, both as to what occasions the entitlement and what he is entitled to. Failure to be or to do that which brings assumed entitlement is what produces guilt.

When a person in our culture steals, the chances are great that he will feel guilty. However, if he comes across a bargain it is highly unlikely that he will feel guilty if he takes advantage of it. The greater the bargain the more pleased he is likely to be. It is the same in therapy. The patient for whom special concessions are made through receiving a cut-rate fee from a private physician may possibly feel guilt. But when he pays a small fee or no fee at a clinic it is comparable to his attending a sale and finding a bargain. He is not guilty about taking what is freely offered.

If there actually is guilt by reason of minimal fees in a clinic, it may relate to his over-all pattern of trying to get something for nothing, or from inner awareness that he is basically a cheat or a thief. I can scarcely see it as an isolated detail in the patient's existence. There is also the possibility that he may feel guilty over his veiled rejection of the therapist because he assumes 1. that he must appear to like the therapist if he is to receive help, and 2. that the therapist cannot be competent or he would not be giving away his time.

It may be well to turn from the patient to the therapist in searching for clarification regarding the guilt which allegedly is present in clinic patients. When the therapist is paid for his time and skill, either in a clinic or in private practice, he is likely to be less involved with his own economic problems than if he is not paid. It is therefore possible that the guilt he notes derives from his own feelings when he is not paid for his services by a clinic. It might be projection, or it might actually be engendered by the therapist as a result of his preoccupation with money and fees.

The therapist commonly has good reasons for this preoccupation with money, inasmuch as his formal training quite probably has stressed money as a most important symbol of interpersonal relations; he has his ear attuned to this aspect of the patient's behavior as much as he does to sex or to hostility. If the therapist is donating his time because he feels it is his civic or professional duty it is not strange that he should think of the patient's economic state with some negative emotions. If the therapist is in the learning process himself and must therefore accept non-paying patients, it would be easy for him to engender guilt in his patients. When one is weary of short rations, of all out-go and no income, it is hard not to imagine the therapist injecting his own problems into the sessions.

Whereas money will always be a possible focal point for therapeutic attention, it is entirely possible to carry out effective analytic psychotherapy with no more emphasis on this area of behavior

than on any other. By and large, in private practice fees are discussed in the first session, bills are sent and fees collected at monthly intervals, and therapy proceeds without further attention to the price of treatment. The same is true in those clinics in which I have worked. From time to time it becomes apparent in both situations that this routine handling of fees is inadequate and requires special attention. At this point fees are grist for the analytic mill.

For the young therapist it is comforting to have the course charted and specific and identified points of reference to grasp—such as money and fees —for use in the analytic process, but there are invariably so many other important details to note and to use analytically that essentially automatic concentration on fees tends to becloud the total picture. However, whoever finds that clinic patients have a sense of guilt by reason of fees needs first of all to ascertain that the guilt is not the product of his own problem and that he is not merely involved with an aspect of counter-transference.

"Being analyzed" is no guarantee that one is free from neurotic behavior, either in his personal or his professional life. There is a standing and possibly well-founded joke to the effect that one can spot an analyzed person by the freedom with which he can be nasty. Therapy can be no better than the skill and wisdom of the therapist. To be experts, in fact as well as in name, implies that the therapists themselves shall have achieved some stature in the art of living. I note with satisfaction that this present A.P.A. Convention is giving far more attention to the therapist's own processes as they relate to what goes on in treatment than has been customary in previous sessions.

The time is past when we may regard analysis as the technique of choice for patients with neurotic symptomatology irrespective of the kind of person who has the symptoms. Neither free association, nor passivity, nor the couch in and of themselves can bring about a reordered way of life to most patients. The therapist, whether he will or not, for good or for ill, participates. True skill is the resultant of a happy combination of technique plus wisdom. Wisdom cannot be learned from a book, nor is one born with it; even a training analysis cannot provide it. Sometimes life itself does not insure it.

Every patient, whether in clinic or in private practice, requires a large measure of skill in the therapist. If we have true skill there will be less of the blind leading the blind, and greater fulfillment of and in our professional tasks.

COMMUNICATION WITH A NON-VERBAL CHILD

BERNITA M. MILLER

THIS STUDY is an attempt to clarify the meanings of a child's silent periods during therapeutic sessions. The six school children presented characteristically by-passed speech as a means of communication even when the therapist tried to elicit verbal responses. Too often therapists have associated silence with guardedness, suspiciousness, withholding, daydreams, and death. To these possible meanings the therapist may respond by withholding herself.

Silence as a deeply entrenched response suggests an early onset, probably the period of infancy. The early use of silence as an adaptational phenomenon was seen in all of the children. One girl, age 10, was silent for 168 sessions extending over three years, in spite of the fact that she used speech remarkably well with her peers from the ninth session on.

At interview, the symptom picture presented by those who referred these children was quite varied. It included such phenomena as bathroom phobia at school, school phobia associated with religious rebellion, immobilization to the point where the child would not take a step or say a word when she found herself noticed by an adult, clinging, violent temper tantrums persisting at age nine, severe mood swings, sex play, daytime enuresis, reading retardation, skin disorders, functional deafness, and daydreams. The silence of these children antedated the other symptoms, but was not noted by the parents. Frequently it was the teacher or otolaryngologist rather than the parent who noticed the lack of a concept of words. Only one of the parents maintained attendance at the clinic even though parent cooperation was urged, and this parent withdrew the child prematurely. One child insisted that its mother not be interviewed beyond the first contact and firmly adhered to this position for all of the 22 sessions. These children did not look to their parents as a help in speech—in fact, quite the opposite. The child's silence was useful to the family as well as to the child.

History of the symptoms themselves is scanty in these cases but, where it is found, indicates that the child's own infantile sounds, sounds other than speech, were the likely source of great fear to the family and child and were forcibly repressed. Dorothy, a child of mixed Caucasian-Negro blood, whose birth embarrassed her white family socially, had been kept almost completely by herself, hidden in the house, not allowed to cry for fear this would reveal her existence to the neighbors. Leonard, who at age nine was still at a loss for the meanings of words, had tried, dur-

Bernita M. Miller, B.A., Toronto, 1932; M.S.S.W., Fordham University, 1946. This is a study of children attending the Catholic Charities Guidance Institute, New York City. Paper presented at International Congress for Child Psychiatry, Lisbon, Portugal, June, 1958.

ing enforced quiet periods between temper tantrums, to learn from his mother. She, however, was a withdrawn woman whose speech was so compulsive and so full of conflicting accents as to be frequently unintelligible. Since a child's crying can be very disturbing to a withdrawn parent, the parent may forcibly try to shut it up. Some of these children seem to have adopted and exaggerated the near-catatonic withdrawal of one or both parents. Ronald, in therapy, looked up as if corrected whenever he heard a noise. Matthew's hearing evaluation at six years, five months, indicated possible derangement not only in understanding the meaning of words but also sounds in general. Margaret rigidly observed the family custom of never speaking about sexual or guilt-provoking material. Reasons for, and degrees of, withdrawal varied, but in all cases the silence had become an entrenched response. Speech had become far too difficult for the child to use in a relaxed way as an ordinary means of communication. Originally it may have represented the response of a frustrated, enraged child. Over the years, however, it had become advantageous to the child in his efforts to deal with his environment.

What has been the use of silence in therapy? It seems to me the child has been striving to use silence positively, as a field for attitudinal relearning where there has been psychic insult. Through silence he has hoped to enter into communication with another. In this way he can open the way to himself and to the world, both of which have been strange to him. Communication is largely learned by imitation of the parent's facial, vocal, and gestural expressions. Imitation, by an alert child, is fastest in silence. It is my belief that the attitudinal imitation of a silent child whose senses are functioning is no slower than that of a talking child. Children use everything available to them for learning. When a child finds that sounds from his own mouth are dangerous he discards them and retires to silence. Just how much a child's senses of sight and hearing are open to him can hardly be known by the therapist. These are the distance receptors and perhaps all the child has available are the nearer ones of touch, taste, and smell. The silent child may have to learn not only to imitate the attitudes of the therapist, but also the facial expressions, gestures, smiles, laughs, words, and the meanings of the words. This accounts, I believe, for the unpredictability of the length of treatment.

It may be difficult to see a child, who maintains silence broken only by rage, as a giving child. Yet, to his parents, the giving of silence was acceptable, desirable, and even demanded. This silence must not be seen as equivalent either to hostility or to the absence of thought. That he makes efforts to communicate in other ways is clearly seen in his play with the therapist.

A child can learn speech even when not speaking, because meaningful speech is a product of a communicating self and not merely of the vocal apparatus. Silence permits the organism maximum receptivity for acquiring tonality and meaning, for capturing the environment. Once when I tired of Dorothy's long silence, I told her I felt tired of talking to myself. She tugged at me and pointed to a butterfly, a worm, and a puddle on the road. I realized that she was well aware of what was going on. She knew that we were trying to open her eyes and ears to the world around her. Although sound had been stifled in her as an infant she really loved sound. Later, when she began to speak, she talked so much in class she was given a punishment consisting of

writing on the blackboard twenty times, "I must not talk in school." In her play therapy, after she had sufficiently punished the adult symbols, she lovingly gathered her symbolic children together and had them touch the sound-making toys, such as the toy organ and the whistling bird. At the same time she explained that what the grown-ups had wanted was that children not touch things or make noise. At the start of her treatment her own sounds had been dangerous to her. In time she came to love both her own and the sounds of others.

When silence is considered neutrality or hostility rather than a possible protective, cohesive symptom, the therapist may have difficulties with the child. If he fails to see it as a symptom he is responding as the family has, but if he attacks the symptom directly he will only confuse the child. The mute child is not stupid and one must not presuppose mental deficiency in dealing with the silent child. He frequently may use puzzles in an attempt to get across to the therapist his bewilderment. Cecelia brought a game in which her persistent effort was to have both the therapist and herself retreat paces. "Go back to the beginning" was an eloquent request for a fresh start at the infantile level. Often she brought a book which meant, "You read aloud to me." These were her offerings. When the therapist begged for even a whispered word, and offered a reward for it, Cecelia's reaction was to become immobile for fifteen minutes. She then spontaneously produced a puzzle and wrote a description of the worker as "an ass." In this way she expressed her rage and scorn at the therapist for not understanding her and her puzzlement. Matthew, in scorn, mimicked the therapist's resorting to writing and gesturing as a substitute for speech, knowing it was he and not the therapist who was or should be in regression. The search for meaning in words was brightly shown by Margaret's finger-painting. She had men "talking to each other and saying nothing."

I have learned that it is not so important for me to know why these children prefer silence. It is far more important that I see and understand what the child does in his silence, and that I let him know by my own speech what I see and understand, or think I understand. The child has, among his symptoms, lack of speech. This is similar to the infant's. What do I do with an infant? Do I not talk and sing to it, tell it what it is doing, what movements its face or hand or foot are making! I have to follow the slightest interest the child shows in anything, even something as seemingly irrelevant as the distant bark of a dog, for nothing in the therapy hour is irrelevant. The economy practiced by the child during his sessions is a wonderful thing to see. He stands half in and half out of the doorway, showing me his ambivalence. He hides, letting me know he feels lost and wishes to be found. He hits at a wall, letting me know he wants the playroom wall to disappear and all his world to be play. He has a little car go up a slant. It is a hill and he has an obstacle. He holds some clay, dirties it, and sits on it. I know it is his own achievement. He makes a ball of clay and puts it in danger of being crushed between two toy trucks. I am to save it, save anything he makes, save him. He wants to cut the clay with a tongue depressor, surely for a reason that is most profound. He can think of no game but Chinese checkers. Checkers, I go when you go. Chinese—we are foreigners, strangers, alien. See the colors of the checkers: we are different, he and I. He wants to win. It has to be by struggling against me, and yet he wants to play with me. He sets a doll

in a corner, isolated, punished by having its tongue cut out. Is it that I may put the tongue back in? He pokes at his watchband to show me that a link is missing. Perhaps a link missing from my understanding. I think to myself that he has great patience with me. He bites, pounds, and again bites the genital area of adult dolls. I follow his meaning as best I can. But when my own speech or his repetition becomes a burden to me, which can surely happen, I defeat both of us if I do not recognize this with him. Otherwise he will catch my annoyance and not comprehend the meaning of it. When this occurs he will become more confused.

Communication is a two-way process. The worker must never be so impressed with her own efforts to get the child to respond her way that she does not see the child's own responses. To repeat, one must respect his silence and if one talks with meaning, the chances are he will gladly learn speech from you, though he may not oblige you with it.

UNDERSTANDING THE CULTURE THROUGH MYTHOLOGICAL STORIES

RAMANLAL PATEL

RELIGION plays a highly significant role in determining the patterns of culture of the people of India. The various creeds create stories to express to their followers the patterns of living to which they wish them to adhere. In these stories certain symbols are effectively used. The symbols are needed to communicate both with the external world and with one's internal state of being. Where the individual is fully in touch with himself he can symbolize his inner experience freely. Psychotics cannot communicate with others or even with themselves, since they have difficulty in forming clear symbols.

The most common symbol used by almost all creeds is that of the snake. We have sufficient data to prove that symbolically the snake represents our instincts. Like the snake our instincts are believed to be supple, fascinating, agile, and poisonous.

The worshippers of Vishnu (Krishna), of Shiva, and of Mahavir (Jain) constitute the followers of three important religious creeds in India. The believers in Vishnu represent him as resting on a bed made of the coil of a huge snake which further protects him by holding its hood over him. Symbolically this means that even when he sleeps, Vishnu must keep his instincts repressed. Only through successful repression of instincts can a man develop the strength to protect himself from the onslaught of his impulses.

The story is told that Vishnu (Krishna) as a small boy once had to fight with the king of the cobras. During the course of the battle, the wives of the king became frightened that their husband would be destroyed and they pleaded for his life. Krishna explained that he was not out to kill his adversary, but merely to gain ascendancy over him. The symbolic meaning of this is that Krishna's sexual instincts were very strong—deadly as the cobra's poisonous assault and frightening as the monsoon thunder. Only through a determined, titanic struggle can they be brought under control. This is how the Vaishnav religious sect regards human instincts; they are too formidable to be destroyed, but must be controlled.

Another story tells that the earth rests on the hood of a cobra. The people believe that if this cobra ever shakes its hood the earth will be flooded and humanity will be destroyed, except for Krishna, who will survive as a child on the leaf of a tree. Once again we have the symbolic representation of the ego

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Mr. Ramanlal Patel, M.I.P.S., Vishra Bharati University Graduate, is a member and training analyst of the Indian Psychoanalytical Society, and author of *View of the Mind* (translated from Gujarati), *Case Studies, Upbringing of Children, Our Dreams* (In press). Article in Samiksa, official journal of the Indian Psychoanalytical Society.

being flooded by uncontrolled instincts and the admonition to learn such control during childhood.

In another group of believers, Shiva is represented as befriending a snake and wearing it coiled around his neck as an ornament. This symbolizes fearlessness, in that one's instincts are not to be feared, rejected, or destroyed, but must be accepted as friendly.

In this connection there is another myth about Shiva in which the gods and devils procure a divine nectar by churning the seven seas with a huge snake. A great deal of poison is released in the process and they search for a way to dispose of it. Shiva settles the problem by swallowing the poison and retaining it forever in his throat. This act of swallowing is the symbolic expression of containing, namely, that those alone who contain their instincts can live with them fearlessly. To me the throat, the seat of speech, sound, and self-expression, symbolically represents the ego. It is to be noted that when one is in conflict the throat often gets affected. One wants either to throw up or gulp down.

Both Krishna and Shiva teach us, though in different ways, not to fear our impulses. Both recognize their strength. Krishna wants them completely controlled and his followers believe in discipline and ethical values. Shiva advocates containment and his followers strive to develop fearlessness. Both regard the instincts not as sinful but as creative and therefore worthy of worship. It is told, in a mythological story, that Shiva once destroyed his sexual instinct because his deep meditation was disturbed by it. But he continued to be affected by it and became enchanted with Parvathi, whom he married. At her intercession, Shiva revived his sexual instinct (Kam-Deva), gave him an invisible (i.e. formless) existence, and made him into a god, who would be worshipped by all.

Shivaism has spread all over India, and the worship of sex and the reproductive organs, has become predominant. Thus, sex was fully accepted by this religious group as the primary need of life. Sex was not condemned; on the contrary, the erotic element predominated in all religious art.

Mahavir had an attitude toward instincts which differed from those of Krishna and Shiva. He believed in nonviolence without hating violence. His belief is expressed in a legend. Mahavir was once bitten on the toe by a fearful snake believed to possess 100 bags of poison. Milk, not blood, gushed forth from the bitten area. Mahavir blessed the snake instead of striking back at it. Symbolically this legend, which embodies the principles of the Jain creed, says that we should love and not hate our instincts, no matter how poisonous, fearful, and troublesome they may be. If we love them, they cease to be destructive; their poison is converted into the milk of love. Mahavir's conviction was that we should treat our sexuality and aggressiveness without fear and hatred.

These three religions differ from each other fundamentally in their attitudes toward instincts, and these differences are reflected in the everyday living of people. The followers of Krishna subject their children to severe discipline, in line with the teaching that one should control one's impulses, should be worshipped, and hence never feel guilty. Among the disciples of Shiva, sex is not a sin, it is divine. Children brought up in such families therefore have no sense of shame or of sin. A follower of Shiva would never accept an analytic interpretation to the effect that he had guilt feelings about sexual impulses. Among the followers of Jainism, the children are taught not to hurt or

kill any living thing. These people are vegetarians and believe that if they kill they will suffer the same amount of pain they have inflicted on others.

It is obvious from all this that the analyst must know the religious and cultural background of his patient. Interpretations made in a text-book fashion, without a consideration of these factors, will lead to an increase in the patient's resistance. This resistance against the analyst is not necessarily irrational, rather it is a refusal to accept inaccurate interpretations. Thus, an interpretation made to a follower of Jainism that his vegetarianism indicates a deep sense of guilt is unscientific and misleading.

Summary

Certain differences between Krishna, Shivaism, and Jainism have been pointed out. These differences are reflected in the everyday lives of the followers of these creeds. Effective analysis is possible only if the analyst is familiar with and takes into account the cultural and religious background of his patient.

BOOK REVIEWS

THE PSYCHODYNAMICS OF FAMILY LIFE, Nathan W. Ackerman, M.D. 379 pp. Basic Books, Inc., 1958, New York. $6.75.

From his long years of experience in working with family groups, Ackerman has attempted to communicate some of his concepts of family diagnosis and family therapy. Family diagnosis is the attempt to view an individual with his problems in the larger framework of his family group and to correlate the behavior and emotional integration of the individual with the behavior and emotional integration of his family. This will include awareness of the role of the family in the mental health of a person, the processes of personality integration into family and extra-family roles, the problems and consequences of adaptation to multiple roles with conflicting requirements and reasonable speculation regarding rehabilitation within a particular family group after mental illness. He states, "My central purpose is to evolve a conceptual pattern within which it is possible to define the relations between the emotional functioning of the individual and the psychosocial functioning of the family group."

Family therapy is the involvement of several members of a family in various combinations in therapeutic sessions. As Ackerman puts it, "a systematic therapy of the family must encompass techniques directed at the multiple, interpenetrating relationships within the family and the process of adaptation of family to community, as well as techniques for psychotherapy of individual family members." In his integrated therapeutic program he includes "a psychosocial evaluation for the family," "the application of appropriate levels of social support and educational guidance, and a therapeutic approach to conflicted family relationships." "Individual psychotherapy is auxiliary to and dependent upon an integrated therapeutic program for the family as a social unit." To consider the individual out of context of his family makes it virtually impossible to predict the course of a mental illness, the possibility of recovery, and even the risk of relapse. The results of psychotherapy are very much dependent on the dynamic balance between the individual and his group. Rehabilitation depends upon making maximal use of whatever is healthy, both in the patient and his family.

Throughout this volume, Ackerman tries to explore the psychological processes occurring within the individual, between the individual and his family group, and between the family and the community. He stresses the individual's needs to adapt to a variety of roles in the family setting and the problems arising from the conflicting requirements of these roles. Each person has many roles to live as part of his social identity. As a member of a family, for example, he may be a father, husband, son, and sibling; on the job, boss and subordinate; in social activities or athletic events, active or passive participant. In fulfilling these roles, he may, through compartmentalizing, be able to be expansive in certain areas, and detached or self-effacing in others. The inner conflicts described by Horney, which occur when he is driven by these contradictory attitudes operating simultaneously, lead to the need for solutions which will enable him to function more effectively in certain roles. In the process, however, new problems arise in other roles. Ackerman gives some illustrations. In one the roles strengthen each other—the man who is a businessman, Rotarian, and captain of a bowling team. In another, the roles are antithetical, namely to be a soldier, family man, and independent entrepreneur. A woman may be able to fulfill the role of a wife, but not

a mother; a man may be a successful political leader but a poor husband.

He dwells at some length on the theoretical and clinical aspects of family diagnosis and identifies healthier and sicker patterns of integrating within a family. In a family where there is predominantly healthy integrating the members are capable of fulfilling a range of social roles. They have a psychological identity which is not static, but which evolves and changes through time and which consists of strivings, goals, expectations, and values. They also have a stability of behavior expressed as "the continuity of identity in time, the control of conflict, the capacity to change, learn, fill new life roles and achieve further development, and finally the complementarity of family role relations." In sicker families the self-concept or identity tends to be conflicted, fragmented and confused. Stability gives way to conflict, anxiety and poorly controlled symptoms, with decompensation, disintegration, regression, breakdown of communication, and emotional alienation. The clinical pictures we see are those of the familiar neurotic, psychopathic, and psychotic disorders. Much case history material is introduced to elucidate his principles.

In a section on special techniques he presents a guide for securing data leading to family diagnosis, criteria for evaluating marital pairs as a couple and as parents, and an outline for estimating the child here and now. He directs the attention of the observer toward the past and current interaction of the couple and suggests that an appraisal be made of the damage to the relationship resulting from the neurotic conflicts and of the residual health in the relationship. He is more specifically interested, for example, in the relationship between the strivings, the values, and the actual performance of the family, the individual personality structures, and the integration of the members into family and ancillary roles. In estimating the child he considers among other things its adaptation to external reality, interpersonal relations, quality of affects, anxiety reactions, patterns of control, defense patterns, and central conflict.

In discussing individual psychoanalysis and family psychotherapy he makes clear his belief that each form of treatment offers something not found in the other. Specifically, he maintains that psychoanalysis is better fitted to deal with "those aspects of intrapsychic pathology that have a deep egocentric core and involve a distorted psychic relation to the infant-parent image and to the own body." Psychoanalysis is for him a two-person psychotherapeutic situation. He adheres to the tenet that this situation fosters a reliving of the symbiotic features of the child-parent unity and reactivates the craving for magical omnipotence. He believes that in a therapy group there is a great variety of possible interactions, all based on face-to-face relations with the participants. Reenactment of conflicts with the entire family group are facilitated. Therefore "group psychotherapy has its sharpest effects on disturbances in socialization and interpersonal relations."

Ackerman sees man as a "biopsychosocial" being continually adapting to changing life situations. Throughout his book he raises many questions and attempts tentative answers. He is not given to either/or speculation. He is interested in furthering the understanding of a person's adaptation to his environment and to the biosocial unfolding of his personality. He explores many problems of children, adolescents, and adults, and offers many valuable suggestions for working through these difficulties with the individual patient, the "family" patient, or the selected group. By stressing shared responsibilities for child-rearing he emphasizes the tendency in the past for putting all the blame on women. Disturbances in mothering are recognized and identified, but disturbances in fathering are also emphasized. He is concerned with the shifting roles in the contemporary American family. At present the father is regarded as weak, inferior, and frightened, in dread of defeat in the competitive struggle with other men. The mother, in an attempt to compensate for her inability to

depend on the man, must develop a facade of being strong, self-sufficient, aggressive, and the domineering member of the family. These factors greatly influence the individual's responses to his parents, to his in-laws, and to his own children, as well as to his spouse. In therapy he establishes levels of contact in accordance with the depth of influence to be exerted on the personality. This includes guidance and re-education by support, emotional release, and clarification of attitudes, reorganization of the conscious functions of personality by the use of authority, advice, and persuasion, and by reorganization and re-education of conscious attitudes, and, lastly, by reorganization of unconscious functions of personality by use of psychotherapeutic and psychoanalytic techniques. With regard to children and adolescents he mentions the use of the therapist as an auxiliary parent and the shedding of conventional social hypocrisies, a phenomenon about which adolescents are particularly sensitive.

Ackerman is aware of the complexity of family therapy since it deals with many levels of conflict. He believes that various phases of therapy must be carried out by different members of a clinical team who must meet periodically with the entire family group to deal with certain shared conflicts. He describes one such family study in detail. He devotes one chapter to problems of family research, the need for the studies, and the difficulties involved in carrying them out.

In stating his personal frame of reference he indicates that he uses the adaptational biosocial position of viewing man in society and modified Freudian dynamics for understanding internal mental processes. In assessing the Freudian position he states that Freud intended to divorce the individual from the group. Freud's active pessimism toward life and social relations made him see the oppositional aspects of the child-parent relationship but fail to see the positive force of love and the joining aspects in family relations. He further tended to stereotype the family members, with the man the dominant figure and the woman a subordinate. He writes that Freud's concepts deal mainly with partial psychic processes, namely, forces within the personality which produce the pathological formations we call symptoms. He "gives a one-sided emphasis on the erogenous zones and fails to lend itself to an integrated evaluation of the functions of personality." He neglects the relationship between the total pattern of personality organization and the dominant modes of social adaptation. He gives insufficient consideration to nonsexual drives, the role of group membership, and the principle of self-image. In questioning the libido theory, Ackerman writes that Freud's views were influenced by the biological orientation and mechanistic philosophy of his time. He states that "they reflected the then current views of cause-and-effect relationships and were conceptually influenced by the law of thermodynamics related to closed-energy systems. He does not consider man a closed-energy system and does not consider such an hypothesis tenable. He believes that there is continuous contact and communication with the environment, that outside influences and materials are absorbed, transformed, and discharged by the living organism. He concludes with "I have been impelled to favor a holistic-dynamic approach to the theory rather than the atomistic-mechanical approach." Those who are familiar with Horney's concepts of human motivation and principles of therapy will find little difficulty grasping the position of Ackerman in this book.

This book would benefit from judicious editing, since the major premises and conclusions are repeated and elaborated to a point where the effectiveness of the argument is often vitiated. At times so many variations of patterns of behavior are presented so closely together that this reader felt overwhelmed even as he was becoming enlightened. Aside from these criticisms, however, one can recommend this important contribution on the psychodynamics of family life to all who are interested in the mental health of the individual, the family, and the community at large.

NORMAN J. LEVY, M.D.

GROUP PSYCHOANALYSIS. B. Bohdan Wassell, M.D. 305 pp. Philosophical Library, 1959, New York, $3.75.

Group therapy is gradually expanding and being practiced on many different levels by therapists of varying degrees of competence, many of whom are ill-equipped to undertake such a formidable task. It becomes difficult to evaluate all of the contributions because there is simply not enough time even to scan them. Much is of poor quality and will bring discredit on group therapy and retard its progress. It is a satisfaction, then, to see a competent psychoanalyst work in this area and discuss his views in this book.

Because of the empirical nature of psychoanalytical psychotherapy answers to important questions vary widely from one analyst to another. How effective is psychoanalysis as a therapy? Which is more important, the personality of the therapist or the tools he uses? What exactly is effective and how? What are the indications and contraindications for its use? And there are a great many others. As if our troubles were not enough, here comes group psychoanalysis compounding all the previously unanswered questions. This does not mean that group psychoanalysis should be held in abeyance, but that the vastness and difficulties should be recognized and the empirical nature and the tentativeness of the formulations remembered. Furthermore, because of its different approach and perspective, group psychoanalysis allows an examination of the above questions against an entirely different background—with, so to speak, different test materials, so that perhaps a better understanding of the therapeutic process in both individual and group work might result. This is what Dr. Wassell has attempted to do in this book. He has given us valuable formulations and some tentative answers to our questions.

Dr. Wassell points out that the goals of therapy in group work do not differ from those in individual analysis, although the paths followed and the nature of emotional experiences are vastly different because of the group atmosphere and the great variety of interpersonal reactions. The book is rich in clinical examples which demonstrate the similarity of therapeutic goals in group therapy and individual analysis.

These brief excerpts are effective in conveying a feeling for the group process, which is so difficult to convey in conceptual terms. Only those engaged in group psychoanalysis can be aware of the complexity of the task, the difficulty in recording one's experiences, noting progress in each person, understanding and formulating how this progress came about, and so forth. It is the personal knowledge of the difficulties of the task that enables me to appreciate the scope of the task Dr. Wassell undertook and the value of his contributions. Each group event is the crossroads of many lives and can be viewed from an infinite number of perspectives. Dr. Wassell tries to focus on those aspects which are therapeutically relevant. At this stage there are great differences as to what is significant, and there are some who feel that what is most important in the group process is exactly that which cannot be described or expressed. There are many approaches, and attempts to be thorough could result in discursiveness, disorganization, and confusion. On the other hand, the attempt to sharpen the focus, while leading to easier understanding, may also result in oversimplification. Dr. Wassell is aware of this dilemma and he has narrowed his perspective and viewed the group process with concepts derived from the "ego" psychology of Horney. In using such a framework the wide scope of human behavior in the group process can be organized and written about. This might mislead the inexperienced to believe that the group process is easily structured and that cause and effect are easily seen.

The heart of the subject is dealt with in three chapters totalling sixty-three pages. The other chapters are interesting, but deal with far less significant material. In these chapters the core of the group process is presented very well, but in a too condensed manner. Dr. Wassell describes the unique contribution and the special advantage of the group in therapy. There is

the uncovering of "universal illusions," the oscillating feelings of pride and self-contempt, the basic anxiety common to all neurotics. Each one learns that the others are as frightened and anxious as he is. Each one asks the same questions as to his identity, how he fits in, how he compares with others, what others value, and so forth. In the process of working together, the group develops a spirit which is an important background of feeling, akin to rapport in individual analysis and almost as difficult to define and demonstrate as the soul. This group spirit develops out of feelings of mutual respect and affection for each other. This most important part of the group process is most difficult to convey in words. What can be most easily described are those intellectual aspects which can be organized into concepts. But the feeling of belonging and the group spirit do not lend themselves to scientific dissection. It is this feeling for self that comes about through identifying oneself with the healthy, simple, human values which is in conflict with the defensive, anxious self as it is revealed in the interpersonal reactions of group members.

In discussing the interactions and interreactions among group members, Dr. Wassell shows how the distorted views of others are gradually corrected within the group process. In being brought together in a group the defense of detachment is gradually eroded and group members act on and react with one another, revealing the extent to which each individual reacts to others in terms of his anxieties. As anxiety and defensiveness lessen in each individual, others in the group can be viewed more in terms of their own uniqueness and less in terms of their individual needs and fears.

This book is extremely hopeful and optimistic about group psychoanalysis. Dr. Wassell is well aware of the limitations of group psychoanalysis, but he does not go into this aspect of the subject in great detail. This phase of the subject is very important for those who are interested in beginning a group practice.

The book would have been better titled, *My Experiences in Group Psychoanalysis.* Each chapter heading promises more than is delivered and much is included in each chapter that belongs elsewhere. This in large part is due to the nature of the subject, as anyone who has done group psychoanalysis realizes when he attempts to categorize group events.

Dr. Wassell has performed a valuable service in publishing his group experiences. His book should be of considerable help in encouraging others to enter this important therapeutic area, and shed further light on all the questions dealing with the therapeutic process.

—SIDNEY ROSE, M.D.

THE PSYCHOSOMATIC CONCEPT IN PSYCHOANALYSIS. Felix Deutsch, Ed. 192 pp. International Universities Press, 1953. $4.

This book consists of five papers and their discussion, given as a symposium on psychosomatic medicine before the Boston Psychoanalytic Society. Each of the five authors covers one aspect of the subject—namely, genetics, dynamics, research, and therapy. While numerous hypothetical concepts are formulated to explain the occurence of psychosomatic symptoms, all are based on clinical observations and integrated within the theoretical framework of Freudian psychology.

Sydney Margolin discusses "Genetic and Dynamic Psychophysiological Determinants." He submits that psychosomatic symptoms are regressive psychophysiological states, wherein "the more archaic the 'fantasy of function,' the more autonomously the organ functions," and the less participation there is of central, integrative regulation. By "fantasy of function," he refers to the subjective concept of any organ in terms of sensations and experiences associated with it. That is, the organ acts as though "infantile homeostatic boundaries" were present; there is an "inhibition of appropriate voluntary mastery of the physiological responses." Although he admits that regression rarely brings about the exact replica of the infantile state of affairs because of later learning and experiencing, he nevertheless distinguishes numerous

levels and partial states of organic and psychological regression with different prognoses in therapy.

As the logical outcome of these theoretical premises, he advocates insight (analytic) therapy for superficial, less complex, less severe types of regression, and superficial or sector therapy for the deeper types of regressive states, with the very sick psychosomatic patient. His concept of "anaclytic" therapy uses what he calls "iatrogenic regression" in the treatment of some severe psychosomatic conditions. This consists of an attempt to artificially "regress" the patient to the preverbal stage of communication of the helpless infant, at which point the analyst takes over the role of mother fulfilling the most elementary needs.

Roy Grinker, in discussing research, formulates his own genetic hypothesis. He is at variance with Margolin on the issue of infantile functioning. He feels that the infantile organism functions "viscerally as a whole, with generalized patterns of reaction to all stress, internal or external" (while Margolin argues for "organ autonomy"), before the central nervous system is sufficiently developed to be able to integrate all systems. During this early "local tissue autonomy" or sensitivity, any stimulus is capable of bringing about changes which may be the basis for future pathological states. He feels that it is only later that maturative differentiation into part functions occurs, which are integrated into "transactional relationships" with each other, involving such factors as symbolization, learning, feed-back, conditioning, and so forth.

He feels that any direction of research on the subject would be satisfactory, but emphasizes the need for the holistic approach in which several disciplines would participate, such as the biochemical, physiological, psychological, and psychoanalytic.

In discussing "Specificity in the Psychosomatic Process," Lawrence Kubie emphasizes that we can hardly talk in terms of specificity because of the confusion and obscurity of the presentation of clinical data, which are colored by the theoretical bias of the observer. This makes for difficulty in checking clinical correlations. He also points up the difficulty of explaining, on currently held theoretical bases, such clinical observations as shifting somatic symptomatology in the same patient; an ulcerative colitis, for instance, being replaced by a dermatitis, then in turn by migraine, and finally giving way to a psychotic break.

He concludes that the search for specificity arises from the "fallacious assumption about specificity of the dynamic sequences in the etiology of the neuroses in general." Thus, while he presents strong arguments against specificity by questioning the classical genetic concept, he admits that he cannot offer an alternative concept to replace it.

Margaret Gerard, on the subject of "The Genesis of Psychosomatic Symptoms in Infancy" gives a report of 38 cases of varying somatic symptoms in children, including such entities as colitis, celiac disease, asthma, eczema, arthritis, diabetes, and obesity. She emphasizes the nature of the mother-child relationship and the personalities of the mothers. She has made a basic observation that in all cases the mothers were "narcissistic and uninterested in the child except as a self-enhancing asset. They resented the exertion involved in the child care, and rarely gained pleasure from the relationship. They lacked mature motherliness."

She also discusses the interchangeability between somatic disorders and psychotic episodes as observed in psychoanalysis, and asks whether the former might not be a substitute for the latter. This would give the infant a better chance for ego development in situations where such development is impeded by emotional illness of the mother.

M. Ralph Kaufman writes on the "Problems of Therapy." He states that since psychoanalysis is the only therapy capable of achieving fundamental personality change, it is therefore the only etiological therapy of psychosomatic disorders. After reviewing the various analytic concepts of therapy, he concludes that most therapeutic systems deal with treatment of symptoms and that any therapeutic influ-

ence may change the psychological homeostatic equilibrium in which the symptom may no longer be necessary. He discusses these problems with humility and points out that our knowledge is limited. He warns other therapists against their unconscious feelings of omniscience, and remarks that our therapeutic results are not always the result of what we believe they are, but of forces the nature of which are incompletely understood.

In general, all the authors decry consideration of psychosomatic symptoms as either specific diseases or in terms of personality profiles. They nevertheless explain such symptoms, *grosso modo,* on the old basis of fixation at an infantile state of organ development and subsequent regression to that state, with both the fixation and regression precipitated by some traumatic external circumstance; this acts as a conflict which is more or less a repetition of the infantile conflict. They differ mainly in particular details as to why such fixation occurs, i.e. whether because of "resistance to developmental advance," or "excessive lability due to organ immaturity," or "local tissue autonomy."

But there are several areas of difference from previously held notions of causality, which indicate a definite progress in thinking. First, there is a significant emphasis by all on the parental neurotic attitudes which will produce a one-sided or distorted focus on particular patterns of body function in the child. Secondly, there is a significant emphasis on ego development in the child, with a corresponding playing down of libidinal forces. This brings in such interesting questions as advance and retreat with anxiety during the learning of progressive normal growth steps; the development and integrity of the body-image; the widening and narrowing of ego boundaries, and the varying psychic representations of physiological patterns depending on life experiences.

Finally, all the authors emphasize the multiplicity of factors and processes required to produce psychosomatic symptoms, whether in causing the original focus or in determining the later somatizing reaction. They now speak in such terms as "adaptive homeostatic phenomena which attempt to achieve an equilibrium, which may vary from moment to moment, and in which one of the resulting variables may be a somatic symptom."

The general tendency is toward an interpersonal, rather than a biological-instinctual, viewpoint, which is closer to our own ways of thinking. The book is the work of competent men who represent the most recent trends on American orthodox psychoanalytic thought. It is a fascinating but difficult field, and here are highlighted the limitations as well as some progress within this theoretical framework. This book makes an interesting and valuable contribution to the literature on this subject.

—SAMUEL SAFIRSTEIN, M.D.

READINGS IN PSYCHOANALYTIC PSYCHOLOGY. Morton Leavitt, Ed. 413 pp. Appleton-Century-Croft, 1959. $8.50.

According to its editor, the purpose of this book is to provide a comprehensive source of both theoretical and practical aspects of Freudian psychoanalysis. He admits that no single volume can adequately cover the profuse literature to date, and he has selected certainly some of the best-known writers to represent what he considers significant problems in the field. Of the 26 papers included, about half have been previously published in other journals. The book is divided into six sections, covering general considerations, psychosexual theories of development, the ego and defensive processes, diagnostic problems, the application of analysis to basic psychology, and the relationship of psychoanalysis to allied fields.

Much of the material is either a repetitive presentation of Freud's original writings, a restatement of classical principles, or a review of the literature after him—for instance, Leavitt on "Freud's Psychological System," Fries on the "Latency Period," Hartmann on the "Ego Concept," Arlow on "Drives," Fleiss on "Thought as Expressed in Dreams." While such articles are necessary as part of a total presenta-

tion, for simple completeness, or to clarify or summarize for the student who does not wish to refer to the original work or article, they do nothing to advance knowledge of the field or to increase the stature of the book—except through the prestige of the authors.

What was more interesting to this reader was the fresh reinterpretation of some of the well-worn Freudian ideas. For instance, Buxbaum, in her discussion of psychosexual development, while still staying within the framework of instinctual stages, also emphasizes to what a great extent external exigencies may modify these phases. Such conditions might include the absence of parents, distorted parental influences, such as anxiety or neurotic attitudes, or concomitant developmental (ego) changes like speech.

Likewise, Helena Deutsch, in her study of the "Imposter," while still explaining such behavior on the basis of ego-ideal concepts, brings up such issues as self-identity and its acceptance, "as-if" personality roles, exaggerated status needs, and devaluated inner self-opinions. The type of viewpoint exemplified by these two articles and several others certainly represents an advance from rigid classical analytic concepts.

A second significant aspect of the book lies in several papers which present new concepts, however they might be based on previous orthodox views. Such is the excellent paper by Josselyn on "Adolescent Psychology." This covers a notable gap in classical psychoanalytic thinking and she applies original notions. For instance, she brings in a concept of character structure with some similarities to Horney views, of intrapsychic conflict between such strivings as dependency and self-assertiveness, hurt pride, and body-image.

Novey, in his paper on "Superego and Ego-Ideal," asks that more attention be paid to character structure during analysis, and for a re-evaluation of the entire concept of ego-ideal. He stresses that memories may play a role not only as the expression of genetic repressions, but as significant experiences in their own right in the present analytic and real life.

Ekstein, discussing the nature of the interpretative process, emphasizes first how interpretations will vary with the personality of the analyst (beyond the usual counter-transference factors); secondly, he decries the use of interpretations as explanations, and with it the use of causal factors to intellectualize the analytic process; third, he points up the intuitive and experiential aspects of analysis as of primary importance, and the need for total communication between analyst and patient.

Roughly one-third of the articles represent the first or informational type of paper; one-third the second type, with some modification of pre-existing orthodox ideas; and one-third have significant originality. As a simple compilation of papers by outstanding contemporary Freudian analysts, the book is worthwhile reading if it stimulates the student to look further into the various subjects. Unquestionably, the material included here should be known to every practicing analyst, of whatever school, and whether he agrees or disagrees with the principles enounced. I do not feel that the book can be considered a true "source-book," since it does not explore adequately any particular subject or any particular writer's viewpoints. No one book could do justice to the many aspects and views in orthodox psychoanalysis today, let alone the various divergent schools. The more sophisticated practicing analyst will not derive too much that is new from this book, and most probably will have read the articles elsewhere.

But what is definitely significant is the view it gives of the various tendencies which exist in the classical group today, if these authors are to be taken as representative spokesmen. Much of the thinking is still limited within the narrow Freudian framework, but there are some signs—unfortunately, all too few—of progressive, original thinking, of a letting in of newer factual observations and newer intepretations of previous ones.

—JACK L. RUBINS, M.D.

PSYCHOTHERAPY WITH CHILDREN. Clark E. Moustakas. 324 pp. Harper and Brothers, 1959, New York. $5.

Clark E. Moustakas is a staff member of The Merrill-Palmer School in Detroit. He has previously edited a book entitled "The Self." It has been described as the most important contemporary research into the ways of discovering the true self. Among its contributors is Karen Horney. It is not surprising, therefore, that in reading his present work I felt a sense of familiarity.

The subtitle to the present volume is entitled "The Living Relationship." Moustakas calls his therapy "relationship therapy." Relationship therapy, he states, is a unique growth experience created by one person seeking and needing help and another person who accepts the responsibility of offering it. In relationship therapy, the relationship is both means and end. The relationship is the significant growth experience. In contrast, Moustakas says, in psychoanalytic approaches the relationship is the means through which other goals are achieved. As the theoretic approach to relationship therapy Moustakas refers to Rank and Adler.

In relationship therapy there is respect for the unique nature of the child, Moustakas says. I do not feel that this is a valid distinction, as Moustakas appears to imply, between relationship therapy and analytic therapy. Analytic therapy does not fail to respect the uniqueness of the individual. Individual therapists of any persuasion may fail to do so, however.

Another difference between analytic and relationship therapy Moustakas describes as follows: In contrast to analytic therapy where there is a continual examination of the past; in relationship therapy the focus is always on the present, living experience. Here, again, many analysts would say that the past is examined, but only as it is experienced in the present.

In relationship therapy, the therapist listens in order to understand and empathize with the emotionalized expressions of the child. He does not see predetermined sexual symbolism in the child's play, nor does he interpret the meaning of the child's play constructions and the content of play. He regards every situation as a unique, living experience which contains its own requirements and its own method or techniques. The only thing the therapist can do is to help the child gradually to be himself and to make creative, responsible use of his capacities and abilities.

Moustakas does not develop any dynamic theory of personality development. The closest he comes to a theory of mental illness is the following: At the root of the child's difficulty is submission and denial of his self. Somewhere during his growth and development he has given up the essence of his being and the unique patterns that distinguish him from every other person. The growth of the *self* has been impaired because of his rejection in important interpersonal relationships. He is cut off from vital-self resources which would enable him to develop in accordance with his own particular talents.

To show what he means by the loss of self and the significance of its restoration, Moustakas quotes paragraphs taken from a letter written by an adult in psychotherapy. This is from an article written by Karen Horney entitled, "Finding the Real Self."

The major portion of the book consists of verbatim sessions with children. There are sessions with the "Normal Child," sessions with the "Disturbed Child," the "Creative Child," and the "Handicapped Child." There are also chapters dealing with "Counselling the Parents" and "The Therapist and the School."

While this volume adds no new dimensions in terms of understanding personality development, I feel it is a valuable book from a clinical viewpoint. There are too few attempts made to bring the therapeutic situation alive. This book attempts to do so, and with considerable success.

—ROBERT L. SHAROFF, M.D.

NO AND YES: ON THE GENESIS OF HUMAN COMMUNICATION. Rene A. Spitz, M.D. 170 pp. International Universities Press, Inc., 1957. $4.

No and Yes by Dr. Rene Spitz is the sixth in a series of investigations on "the ontogenetic beginnings of man—the processes through which the species achieves the dignity of the human being. Its subject is the inception of semantic and verbal communication." He explicitly states in his foreword that Freud has answered the major problems of the organization, structure, and function of the human psyche, and that this investigation is a minute study of one of the building blocks in Freud's theory. The reader is forewarned, therefore, that there will be no new ways of understanding "the genesis of human communication," but only affirmation of a previously held theory. Dr. Spitz's narrow approach is further emphasized by an astounding statement in his introduction that, "It is surprising how little has been published by psychoanalysts on communication. . . . There is even less on nonverbal communication." He cites a handful of references, acknowledging only the Freudian analysts. In spite of the stated bias, however, the subject is of the highest importance to all analysts and students of human development, and therefore deserves our closest attention.

In essence, this study is mainly an attempt to integrate three types of behavior, which involve negation and its communication. Dr. Spitz observes that deprived infants "rotate their heads around the sagittal axis of the spinal column" when approached by adults as part of their avoidance pattern. These movements he calls "negative cephalogyric motions." He further observed that infants in searching for the breast rotate their heads from side to side in rapid sweeps until they locate the nipple. This is called "rooting behavior." Finally he observes that around the fifteenth month of life children begin to use the head-shaking "no" as a semantic signal. Is there any connection between the rooting behavior, which is behavior of "turning toward"; negative cephalogyric motions, which are motions of avoidance; and the headshaking gesture of "no," which means refusal? Dr. Spitz asks, "How does the motor pattern of rooting, which has fallen into disuse for twelve months or more, become available again to the child in his second year for semantic purposes?" He answers this question by explaining it as a "regression" to relieve anxiety. He amplifies his explanation with lengthy theoretical discussion, interspersed with his observations on various infants.

A general conclusion is that oral experiences are the first building blocks for speech, and that feeding behavior is incorporated in semantic signals. He states at one point that "techniques and modes of communication are developed from the anaclitic situation." This latter statement throws light on the inherent defect in Dr. Spitz's approach. He is not actually studying communication, as he says, he is merely investigating *one aspect* of communication —the "techniques and modes." The important problems in communication deal with meaning, with exchange of feeling, with blocks to communication leading to isolation. Nowhere does he touch on these areas. Even his discussion of the mother-child relationship is highly mechanistic.

One observation made in the book is worthy of further development. The child learns "no" before "yes." He goes through a phase of negating what is presented to him, often when we feel he really wants it. Paradoxically, by saying "no," he means "yes." In effect, he says to the adult, "No, I don't want what you want for me. I am me!"

In the progress of a patient in psychoanalysis, and in the growth of the child, it is crucial for the individual to grow away from this negativistic type of self-assertion and toward the true "yes" of autonomy and self-direction.

Freud said, "In analysis we never discover a 'no' in the unconscious." This is the basis of Dr. Spitz's inquiries. Unfortunately, he approached this fascinating subject with *a priori* conclusions, which have, therefore, prevented a truly creative product. There are a few stimulating moments in his book and it is hoped that perhaps a broader more productive work will someday emerge on this subject.

—ALEXANDRA SYMONDS, M.D.

From Death-Camp to Existentialism. Viktor E. Frankl, M.D. 111 pp. Beacon Press, 1959. $3.

Imagine a group of creatures, barely recognizable as men, exhausted and starved, lying listlessly in the darkness of a cold room in the worst of the concentration camps. They have chosen, yes chosen, to fast, to imperil their lives even further, rather than betray one of their members who has been guilty of a minor infraction of one of the many inhuman rules of the camp. One of the prisoners addresses the others in simple phrases, recounting some meaningful experiences from his past life and from his long study of psychology, philosophy, and religion. He speaks to them of hope and dignity; about the meaning of living and dying; about "suffering proudly." He tells these men, who have no expectation of surviving their brutal experience, that they must stop asking the meaning of life and instead must think of themselves as those who are being questioned by life. He quotes Rilke: "How much suffering there is to get through." He tells each of them that his unique opportunity lies in the way he bears his burden. And he reminds them of why they cling to life. One must live because a child is waiting for him, a child for whom he is irreplaceable. Another because a scientific work must be finished. Each of them must fulfill the unique tasks which life demands from him.

His listeners are apathetic men. They have long before learned not to respond to the daily abuse and beatings of the Capos, or trustees. They have deadened their feeling so much that seeing the dead body of a companion, dragged by the heels, does not even cause them to pause in eating their daily ration of bread. Yet, when the quiet but impassioned voice stops, these men come to him with tears in their eyes and thank him.

This voice was that of the author, Viktor Frankl, and what he experienced and said to them is said to us in this small book, which is so deeply moving and inspiring to read. For anyone who has been reading theoretical and tightly reasoned psychoanalytical and philosophical tomes, this small book will provide a real relief, but a strong emotional experience. Not that it is in any way a trivial book, although it is very readable; Dr. Frankl, writing about his day-to-day experiences as an ordinary prisoner in the worst of the concentration camps, delves into the most important questions that any of us can ask. In the "ultimate" situation in which he was thrown, he had the courage and felt the necessity to ask ultimate questions. Although his answers are similar to those of sages and religious leaders through the ages, they command our attention and consideration because of the contemporary situation in which they were rediscovered, the psychiatric background of the author, and because of their value in having saved not only his life, but also his creative ability and self-respect in situations which were specifically tailored to destroy both.

For instance, he quotes Nietzsche: "If a man has a why for his life, he will be able to sustain any how." He asserts that "it is not what you expect from life that is important, but what life expects from you." By themselves these phrases may mean very little, may even sound trite. But uttered at the right time, by a sincere man in the same desperate circumstances as themselves, the simple truths touched something deep and uniquely human in the prisoners. They were given a peg on which to base their struggle. They were inspired to adopt an attitude of courage toward their hopeless plight, to embrace their suffering as their life task.

Through the use of anecdotes, with almost casually interjected comments, Dr. Frankl manages, without either detachment or undue dramatics, to convey some feeling of the horror, the depersonalization, and hopelessness of men who had been snatched from lives where they were "somebody" and transformed into "literally numbers." As he says at the outset, "This tale is not concerned with the great horrors . . . but with the multitude of small torments." There may be real doubt as to how well he was able to answer his question, "How was

everyday life in a concentration camp reflected in the mind of the average prisoner?" because, in spite of all his protests, Dr. Frankl was obviously not an "average" prisoner. True, he was treated as everyone else (and he points out rather proudly that he did not serve as a psychiatrist, or even a doctor, until the last few weeks). But his concern about the truths in life certainly was stronger than "average." For example, he risked his life while being admitted at Auschwitz, by hiding under his coat a manuscript containing his life's work. Later he writes, "While the concern of most of my comrades was 'will we survive the camp? For, if not, all this suffering has no meaning,' the question which beset me was, 'Has all this suffering, this dying around us a meaning? For, if not, then ultimately there is no meaning to survival; for a life whose meaning stands and falls on whether one escapes with it or not . . . a life whose meaning depends on such a happenstance . . . ultimately would not be worth living at all.' "

One important focus of the book, then, is on an evaluation of ultimate goals and values—on meaning. Usual goals and values simply were not applicable in that situation. Creating, pleasure, or power-seeking were simply not possible for most. Even fantasy, projecting into the future, was possible only on rare occasions, as, for instance, on an occasion when Frankl found his situation particularly unbearable. He imagined himself in a lecture hall, after the war, speaking on the psychology of the concentration camp. At other times he would think of his wife and his love for her. It would seem as if she were actually there with him. It was a means of transcending or escaping from, if you wish, his intolerable immediate reality.

A second important factor Frankl brings in, to add to his prime focus, is that of finding in a hopeless situation a meaning in suffering itself. The added factor, of course, is hope, perhaps more important even if more superficial than the former. In the opinion of this reviewer, however, while the capacity to embrace suffering as one's life task is undoubtedly one of the highest in human development, it is probably given to only a minority of people.

Hoping, however, is a characteristic shared by all of us and it continues even in apparently hopeless straits. Frankl himself found that men died when they lost hope, hope not for some general prize, such as self-realization (here he takes issue with Horney), but for some foreseeable or graspable one, such as release by a certain date. One of the more moving vignettes in the book is the story of the man who confided in Frankl that he had a dream in which a voice told him that the war would end by a certain date, about a month thence. *His* war. When it was apparent that he would not be released by that date the man contracted typhus, always present in the camp. He went into a coma and died on the exact date which had been predicted. His war *was* over.

The "meaning" Frankl finds in hope is very similar to that offered by Camus in *The Myth of Sisyphus,* for example. He concludes that even in a hopeless situation, "man can preserve a vestige of spiritual freedom. . . . The way in which a man accepts his fate and all the suffering it entails . . . gives him ample opportunity . . . to add a deeper meaning to his life."

This is similar to what Karl Menninger related at the American Psychiatric Association recently. He spoke of the miracle which he and other distinguished psychiatrists observed when they visited Auschwitz, just a few days after its liberation by our troops. They found that after enduring the same starvation, hard labor, and humilities as the other inmates all day long, the doctors would meet at night to discuss professional problems. They had developed a regular medical society! And more. With great ingenuity, and risking their very lives, they had assembled, piece by piece, with smuggled materials and tools, an X-ray machine to be used at night to help them in practicing their profession. Of course, there are other elements besides hope in this sort of behavior. There is defiance of the cruel authorities, and self-assertion. Or the life instinct—Eros, as Menninger calls it. Or it may be some need for mental and

physical stimulation, which, as many psychologists today are pointing out, are necessary for growth and probably for life. But hope and the working toward a goal are definitely crucial components. We can understand that the very difficulty and danger and challenge involved made the experience all the more meaningful and life-saving in these concentration camp victims, who were prevented by their environment from achieving the small satisfactions that, under more normal circumstances, are a part of everyday life. It is as if they had to concentrate their life-saving energies into a small cauldron of one or two enterprises, or fantasied enterprises.

In contrast to Dr. Menninger's doctors, Viktor Frankl and the men with whom he lived were not able to find creative expression in action or even in intellectual activity with colleagues. Probably because of more outward restrictions, his only hope lay in developing his own resources, and in his concept of "spiritual freedom which cannot be taken away." He anticipates the objection that some people will discount his philosophizing as "mystical and impractical" by stating unequivocally that "they were the only thoughts that could be of help to us."

Those of us who live in our own private prisons may question whether the concerns of Frankl, in the ultimate situation of a life without present or future satisfactions, have any or sufficient meaning for us. Or we may wonder whether the choosing of an inner attitude of courage and pride in suffering might not be considered neurotic, a flight from reality. Of course it can be. But, in my opinion, we must heed Dr. Frankl's warning against a psychiatric tendency he calls "pathologism"—exclusive emphasis on the sick aspects of personality.

He suggests, for example, that, "A person is not necessarily sick if he thinks his existence is meaningless." And in a similar vein, the prideful acceptance of suffering as one's lot may, if there really is no other alternative, be a supremely human act. It may take into account greater realities, not only the physical realities of cold, starvation, pain, and fatigue, but also the reality of the cycle of life and death and the reality of the significance and insignificance of each person in the whole context of life. The very aspects of life that are discarded by some as unreal are the ones that make life worth living. Are hope, courage, faith, and love to be considered unreal?

Out of his experiences Frankl has devised a form of psychotherapy which he has called Logotherapy.* It is aimed at the treatment of those neuroses he has designated as "noogenic neurosis," namely, those caused by a lack of meaning in life. "Noogenic neuroses have their roots not in psychological complexes and traumata, but in spiritual problems and moral conflicts." With the thesis that "every age has its neuroses, and every age needs its own psychotherapy," he discards as main factors in the formation of neurosis in our age both Freud's will-to-pleasure and Adler's will-to-power. In their place he has put as man's primary concern the "will-to-meaning." When the will-to-meaning is frustrated, he points out, its place may be taken either by pleasure-seeking or by power-seeking. For example, he states, "Often, existential frustration leads to sexual compensation."

This "will-to-meaning" has been made the central theme in his philosophy and therapy. Lack of fulfillment of the "will-to-meaning" is called "existential frustration" and is manifested as boredom. Frankl states that the search for a meaning to one's existence is not a secondary rationalization or a reaction formation or sublimation. "Would I be willing to live, or die, for a 'reaction formation'?" he asks.

Two of the main principles in logotherapy seem to be, first, to help the patient find a future goal, "a personal life task," and second, to teach him that "it does not matter what we expect from life, but rather what life expects from us." The scientific methods used by Dr. Frankl and his fol-

* By Viktor E. Frankl in the Am. J. Psychoan.: On Logotherapy and Existential Analysis, (A lecture), XVIII, 28, 1958; The Doctor and the Soul: An Introduction to Logotherapy. (A book review), XVIII, 194, 1958.—Editor.

lowers in imparting these principles to patients must, presumably, be described in other writings.

From the form of the questions he poses, as well as from his entire approach, we can see that he is far from being a detached scientist. This does not mean that he is not passionately concerned with learning more about the human condition and transmitting his knowledge to others. His curiosity and interest in his own and others' reactions even in the most horrifying situations is ample evidence of his basically "scientific" attitude. But his knowledge comes from the inside—inside the experience and inside himself. That he is able to share some of it with us in such a beautifully written and moving book is something for which we can only be grateful. I strongly recommend *From Death-Camp to Existentialism.* This little book is truly a gem.

—SIDNEY ROSEN, M.D.

PRELOGICAL EXPERIENCE. Edward S. Tauber and Maurice R. Green. 196 pp. Basic Books, N. Y. 1959. $3.75.

At the present time, many analysts are questioning whether the events and experiences which occur during psychoanalysis are explainable on the basis of logical, scientifically verifiable principles. Involved are such questions as whether psychoanalysis is a science or an art; whether intuition or extrasensory perception play a role in the understanding of the patient's and analyst's mutual communications; and the nature of the emotional interaction between patient and physician. Even more to the core of the matter is the question of the nature of intrapsychic function: Do our currently held concepts and psychological explanatory principles adequately account for all, or even for much, of the phenomena of human experience?

This book raises these questions implicitly by focusing on "the vast continuum of more or less diffuse referential processes that operate at the margin of awareness and come to the edge of focal attention rather than being divulged through logical formulations of the conscious mind . . . such as dreams, daydreams, extrasensory perception, insight, creative inspiration, hunches, etc." These processes would certainly have been traditionally included within the unconscious or preconscious. These authors are hesitant about using these classical concepts, which they replace by prelogical experiences. This reviewer is in agreement with this attitude, since he has long felt the term "unconscious" to be outmoded and in need of thorough revision.

Certainly much has been written, both within and without the orthodox framework, about unconscious functions, such as wit, slips of the tongue, dreaming, symbolism, and transference. But these have been rather scattered, piecemeal observations, more in the spirit of attempting to broaden previously held Freudian concepts to include new observations. And while this approach has greatly increased our knowledge of such phenomena, up to a certain point, it has limited further understanding beyond that point. The emphasis has been more on content than on process and experience.

Four developments in modern psychoanalysis are now increasing interest in this area, and also permitting a fresher approach to it. These are the lessening emphasis on libidinal motivational forces, with greater appreciation of the so-called "ego" and cultural influences; the recent upsurge of research in perceptual phenomena, as exemplified by Fisher in subliminal perception and Kleitman in dreams; the growth of interest in the phenomenological and experimental aspects of psychic function; and the slow and grudging recognition by analysts of the possible role of extrasensory factors in communication, as has been claimed by such psychologists as Rhine in this country and Soal in England.

This book not only emphasizes the importance of these pre- and unconscious phenomena, but it highlights their significance in the psychoanalytic process. About two-thirds of the book is devoted to bringing together some of the more significant recent investigations and theoretical work dealing with them. This is valuable in correlating the different areas in which prelogical processes are at work: in gen-

eral experience (the hunch, intuition, mutual recognition of each other by homosexuals), in dreams, in creative imagery, in the symbolizing process of language, in subthreshold perception during the normal state or during states of altered consciousness, in extrasensory perception, and in the transference.

For about one-third of the book, the authors discuss the clinical application of these phenomena and present a limited amount of clinical case material. They focus particularly on counter-transference as sub-threshold communication—for instance, analyst's dreams being presented to the patient—and on the meaning of dreams as messages.

The authors base their viewpoints on those of Sullivan in tracing the development of the self through infancy and childhood, in order to explain individual differences in both the maturation of the symbolizing process and in the exclusion from consciousness of particular psychic contents. In the adult, in the context of here-and-now experience, this same process is said to operate as "selective inattention," an aspect of the "security operation" to avoid anxiety. The authors propose that this "dissociated" or "inattended" psychic content operates actively in a "subpresentational" or sub-threshold mode of awareness, and not only in relation to perceptions but also in relation to self-awareness.

The authors urge not only that the analyst take cognizance of these prelogical processes and responses, but also that he actively use them in therapy, and present them to the patient—whether they come from himself ("countertransference reactions") or from the patient. This is particularly so in regard to dreams, where they emphasize the analyst's need for attention to his intuitive reaction to the dream as a presentational experience, "like poetry," rather than a structured, interpretative one. This is a call for a more involved activity on the part of the analyst, to allow himself to express his own feelings more spontaneously.

The book is stimulating in that it directs the reader into aspects of psychoanalytic experience and technique which have hitherto received too little attention. The spirit of the book is refreshing in its appeal to openness in interpretation, to dynamic process rather than structured relationships, to investigation rather than acceptance of theoretical dogma. It raises questions, but gives few answers, and in this fulfills its sub-title, "An Inquiry into Dreams and Other Creative Processes." This reviewer would like to see the next edition more complete, more inclusive not only of theoretical and experimental work already in the literature, but also of more of the authors' personal creative thoughts. Many things are touched upon that could profitably benefit from greater discussion—for instance, the nature of consciousness, awareness, and of unconscious functioning; concepts of the self; the role of emotional processes both intrapsychically and in the doctor-patient relationship. This book should serve as a springboard for continued exploration of a fascinating subject.

—Jack L. Rubins, M.D.

ANNUAL REPORTS

The Association for the Advancement of Psychoanalysis

The Association continued to grow. Ten new associate members and four full members were elected. On the occasion of his eightieth birthday, Dr. Kurt Goldstein was elected as the first honorary member in appreciation of the contribution his holistic concept of human nature has made to the advancement of psychoanalysis.

The newly created Karen Horney Award aroused great interest among psychiatrists and psychoanalysts in the United States and overseas. The first Karen Horney Award was presented to Dr. Thomas Hora for his paper, "Ontic Perspectives in Psychoanalysis," on the occasion of the Karen Horney Lecture at the New York Academy of Medicine.

The Seventh Karen Horney Lecture, preceded by a dinner, was given by Dr. Leo Kanner on "Centripetal Forces in Personality Development." The Academy Lectures reflected recent developments, including the influence of existentialist and holistic thought on psychoanalysis. The Interval meetings served the clarification of our own position regarding theoretical and clinical aspects of psychoanalysis.

During the annual meeting of the American Psychiatric Association, our Association, in cooperation with the Karen Horney Clinic, arranged a Round Table on "Variations in the Dynamics of the Analytic Relationship in Clinic and Private Practice." Dr. Frederick Weiss was the moderator. The panelists were Drs. Camilla Anderson, Louis Azorin, Nathan Freeman, Louis Hott, Arnold Pfeffer, Bella Van Bark, and Earl Witenberg. Representatives of various psychoanalytic clinics discussed the ways in which the clinic setting, as reality and as symbol, affect the patient, the therapist, and the relationship.

Four members of the Association—Drs. Benjamin Becker, Harold Kelman, Frederick Weiss and Antonia Wenkart—presented papers at the IVth International Congress of Psychotherapy, in Barcelona, the main theme of which was "Psychotherapy and Existential Analysis."

The American Journal of Psychoanalysis extended its circulation in the United States and in many foreign countries. The Auxiliary Council successfully continued its workshops and discussion groups on various aspects of mental health. The Association is preparing a reorganization of its public psychoanalytic education program. The Association continued its membership in the World Federation for Mental Health and the Academy of Religion and Mental Health.

The Program Committee of the Association was enlarged by inviting representatives of the American Institute for Psychoanalysis, the Karen Horney Clinic, and the Candidates' Association. The Association participated in a year-end party with those organizations and it welcomed an invitation to combine the facilities of Association, Institute and Clinic. The integration of these three institutions, we feel, will effectively promote the theoretical and clinical advancement of psychoanalysis.

For the fall of 1960, the year in which Karen Horney would have celebrated her seventy-fifth birthday, the Association is planning a symposium on "Alienation and the Search for Identity." Alienation, as an individual and as a social phenomenon, has moved into the center of our time.

Frederick A. Weiss, M.D.
President

American Institute for Psychoanalysis

BOARD OF TRUSTEES

Since June 1, 1959, the Board has met eleven times.

The Board certified Doctors Morton B.

Cantor, Arnold Davidson, Albert L. Deutsch, Ralph N. Harris, B. Joan Harte, Aaron E. Koblentz, Louis Landman, Norman J. Levy, Ervin A. Maurer, Jason Miller, Geoffrey F. Osler, and Ralph Rosenberg to practice psychoanalysis.

In conjunction with the Association and the Candidates Association, the Board voted to take part in a joint annual social affair. A committee of the three groups, represented by Drs. Eleanor Crissey, Ellis Mischel and Sara Sheiner, chairmen of their respective committees, was appointed. A successful and well-attended dinner dance was held at the Hampshire House on June 13, 1959.

The Board empowered the Faculty Council to accept or reject any candidate's resignation.

Karen Horney Clinic: The Board directed the Medical Director of the Karen Horney Clinic to present a bi-monthly report in person. It also appointed the Medical Director as a consultant to the chairman of the Clinic Committee of the Board of Trustees.

The Clinic informed the Board that it was offering a grant of $5,000 annually for a clinic fellowship, which the Board accepted with thanks. The Board considered and approved the criteria for admission of applicants under the provisions of the Karen Horney Clinic Fellowship after consultation with the Faculty Council and the Medical Board of the Karen Horney Clinic.

A committee for combining the housing facilities of the Clinic, the Association, and the Institute was appointed.

Dr. Paul Lussheimer was appointed consultant to the Medical Board of the Clinic and also Attending Psychoanalyst to the Clinic for the year 1958-1959.

The Board carried out the directive of the membership passed at its October 8, 1958, meeting. It informed the Karen Horney Clinic that the Institute wished to explore the possibilities of combining the facilities of the Karen Horney Clinic with the American Institute for Psychoanalysis. The Association was asked if it wished to join in this venture.

A Department of Speech Therapy was established in the Clinic and Dr. Dominick A. Barbara was appointed physician-in-charge of this department for the year 1958-1959.

Confidential Information: The Board resolved that when a request is made to a training analyst by any of the following: 1) other psychoanalytic institutes, 2) institutions and organizations requiring confidential information, 3) hospitals, or 4) private physicians, the training analyst, after having received written permission to release such information from the candidate, shall request the Faculty Council for permission to release any information regarding a present or former candidate with whom he is working or has worked. The Faculty Council, in conjunction with the training analyst, shall determine whether such information shall be released. It shall be at the discretion of the Faculty Council, in consultation with the training analyst, what information shall be released. The Board directed the Faculty Council to inform all training analysts as to the content of this resolution.

The Board noted with regret the death of Dr. Clara Thompson.

Fellowships: The Board granted fellowships totaling $664 for academic courses to foreign students.

The Board informed the Faculty Council that any individual who speaks for himself does not require authorization to use any titles he might have at the Institute.

The Board appointed Dr. Lester E. Shapiro as chairman of a committee of one to investigate the possibilities of obtaining scholarships and similar funds. Dr. Shapiro reported that he had been in communication with the National Institute for Mental Health and stated that the Institute would be eligible for grants for courses given to general practitioners. The Faculty Council was directed to study the material from the National Institute for Mental Health and formulate possible courses suitable for general practitioners.

An Interim Constitutional Committee was formed at the April membership meeting to consider changes in the Constitution. Drs. Harold Kelman, Sara Sheiner, and

Nathan Freeman were appointed to this committee.

The membership elected Drs. Nathan Freeman, Ada Hirsh, and Frederick Weiss as members of the Board of Trustees for a period of three years.

The Board of Trustees elected the following officers for the year 1959-1960: President: Dr. Nathan Freeman; Vice-President: Dr. Harry Gershman; Secretary: Dr. Lester E. Shapiro; Treasurer: Dr. Ada Hirsh.

NATHAN FREEMAN, M.D.
President

KAREN HORNEY CLINIC REPORT

Owing to the combined efforts of the staff, lay and professional, and the American Institute for Psychoanalysis, the Karen Horney Clinic has continued to develop its program. Committees were chosen by the Medical Board to develop the facilities of the library, prepare a medical newsletter, organize a speakers' roster, and promote professional relations. In addition, a research group was selected to choose projects for the coming season.

Through the joint efforts of the Medical Board, the Lay Board, and the Board of Trustees of the Institute, a yearly fellowship has been made available for psychoanalysts in training. In the future it is anticipated that several such fellowships will be granted during each academic period.

Another innovation has been the establishment of a speech-therapy department and a group-therapy program for adolescents. Local high schools and community agencies have been notified that the Clinic is now ready to deal with young people who have specific learning problems. It is believed that this work will contribute to a broader understanding of troubled teenagers and may even help in comprehending and treating juvenile delinquents.

Fifty-four doctors, aided by two caseworkers and a psychologist, have cared for the weekly average active treatment load of ninety-seven patients. During the past year, 400 children and adults have been helped through therapy, consultations, and intake studies. In the year ahead, with the increase in our medical staff, even more patients will be served.

Three medical staff meetings have been held this year. These have afforded an excellent opportunity for teaching and learning, since our colleagues have exchanged views on theoretical and practical points of therapy. The sessions have been well attended by our own staff, as well as by residents of various psychiatric hospitals. The following topics have been discussed: "Evaluation of Therapeutic Goals in a Psychoanalytic Clinic and in Private Practice"; "A Case of Schizophrenia—Descriptively and Dynamically"; and "Modern Trends in Forensic Psychiatry and Criminology." This last subject, an enlightening view of treatment of psychopaths and criminals in a community atmosphere in Holland, was presented by Dr. P. A. H. Baan, of the Dr. H. van der Hoeven Clinic for Criminal Psychopaths.

In May, 1959, at the American Psychiatric Association convention in Philadelphia, several members of the Clinic participated with representatives of other groups in a panel discussion in which the quality of work and the goal of treatment in clinics and private practice were compared and contrasted. The value of the Clinic as a training and research auxiliary to the Institute became quite apparent.

The child-guidance and group-therapy departments have held many conferences and discussions in a team setting. Plans are underway to expand these units and to train more doctors in child analysis. The casework and psychological staff, as well as the screening analysts and staff doctors, have been able to provide valuable consultation service to numerous individuals and agencies throughout the community.

The future looks bright and we anticipate accepting more patients for treatment and providing even more intensive treatment for those in therapy. Through the fellowship program, the research and training activities, and the services to the community, we are participating in furthering the cause of mental health.

LOUIS R. HOTT, M.D.
Medical Director

THE DEAN

The new six-year program began to show its effects even before it was announced. This was manifest in an increase in candidate applicants. More recently there has been a lull. It is too early to determine the long-term consequences of this new program in stimulating greater interest in psychiatrists coming for training.

The number of applicants for starting first supervision is, of course, greater than heretofore because this is the first time supervision is being started at the end of the second year. With at least one year of prior supervisory work with patients at the Karen Horney Clinic, candidates come better prepared for this first of the now-required three supervisions. Also the Faculty Council has a better basis for making its evaluation of this crucial step in the candidate's training.

With the experience the candidate has had, and with the Faculty Council now having an even broader basis for estimating candidates' progress, the second crucial step in the course in training may be made on a more solid basis. Before this academic year is completed, a greater number of requests to become seniors and participate in advanced technical courses is expected.

In no year since the Institute has been founded have there been so many graduates. A large number of them have resulted from the changed requirements for graduation. It was noteworthy that all preferred to take a third course in supervisory work to the writing of a case study. It is possible that the Faculty Council sensed the wish of the candidates in placing greater emphasis on supervisory work in the new six-year program. Also, progressing at their own tempo, more may come to writing articles for the Journal, case studies, and original papers.

A change in atmosphere has already been noted among the candidates. Where before it was they who were for hurrying through their training and feeling that the Institute was slowing their progress, it has now become the task of the Faculty Council to remind candidates of failure to take courses when given, which if put off for another year, would lead to a stretch-out of their training beyond the six years originally planned.

With time, experience, and an increasing number of graduates, it has become possible to improve the quality of the teaching and to lighten the duties of those who have been doing most of the teaching for so many years, in addition to carrying heavy administrative burdens.

It is hoped that, with increasing maturity in ourselves, broadening the base of participation might make possible more opportunities and stimuli for original work. New teachers, new ways of teaching, and new ideas to teach are an essential for the continuing vitality of the Institute.

HAROLD KELMAN, M.D.
Dean

CANDIDATES ASSOCIATION

During the academic year 1958-1959, the Candidates Association of the American Institute for Psychoanalysis held four membership meetings. It was decided at the beginning of the year to group all our meetings around the theme of treatment. As a result, we had a series of interesting, related topics. The first was on "Transference Problems in the Treatment of Adolescents," by Alexandra Symonds. The second was "Treatment of the Family." Dr. Nathan Ackerman interviewed an entire family of three generations in our presence, and discussed his methods and findings later. The third meeting was on the subject of "Problems in the Treatment of Schizophrenics"; the speaker, Dr. Silvano Arieti. He presented many of his original ideas and practical experiences. The last topic was "The Initial Interview," with Dr. Morton Cantor and Dr. Joseph Vollmerhausen. This was our annual open meeting and we had as our guests psychiatric residents from St. Vincent's Hospital and the Veterans Administration Hospital in the Bronx. The interest and participation in all of our meetings indicated that the concept of a united theme can be developed further with excellent results. The Bulletin continued under the capable edi-

torship of Dr. Sidney Rosen. The articles, reports, and personal comments served to keep us all informed on the varied activities of the psychoanalytic community.

At the conclusion of the year, we had a picnic at High Point Hospital with Dr. A. Gralnick as our host, and a successful dinner at Hampshire House, which was held with the Association and the Institute.

Our committees all carried on their auxiliary functions with great success, and many new ideas emerged for the coming year.

ALEXANDRA SYMONDS, M.D.

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Stanley Lesse, M.D., Editor—15 West 81st St.—New York 24, N. Y.

Editors.

JOSHUA BIERER
M.D., D.Econ. and Soc.Sc.
Medical Director, Marlborough Day Hospital; Consultant Psychiatrist, Runwell Hospital; Hon. Medical Director, Institute of Social Psychiatry, London.

FRANCIS J. BEACELAND
M.D., Sc.D., F.A.C.P.
Psychiatrist in Chief, Institute of Living; Clinical Professor, Yale University; President, American Psychiatric Association.

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All enquiries should be addressed to:

The Secretary,
THE INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY
7, Hollycroft Avenue,
LONDON—N.W.3..
ENGLAND...